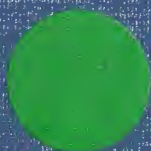


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SOCIAL SECURITY AND WELFARE PROPOSALS

HEARINGS
BEFORE THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
NINETY-FIRST CONGRESS
FIRST SESSION
ON THE
SUBJECT OF SOCIAL SECURITY AND WELFARE
PROPOSALS

OCTOBER 15, 16, 21, 22, 23, 24, 27, 28, 30, 31, NOVEMBER 3, 4, 5,
6, 7, 10, 12, AND 13, 1969

Part 6 of 7
(November 7, 10, and 12, 1969)

Printed for the use of the Committee on Ways and Means



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SOCIAL SECURITY AND WELFARE PROPOSALS

FRIDAY, NOVEMBER 7, 1969

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. James A. Burke, presiding.

Mr. BURKE. The committee will be in order.

Our first witness today is the distinguished Member of Congress from the State of Pennsylvania, Hon. William S. Moorhead.

You may proceed, Mr. Moorhead.

STATEMENT OF HON. WILLIAM S. MOORHEAD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. MOORHEAD. Mr. Chairman, it gives me particular pleasure to see a distinguished Member of the 86th Congress club presiding over this great committee. I am particularly pleased to appear before you under those circumstances.

I am, seriously, Mr. Chairman, very grateful for the opportunity to appear before you and to present my views on some of the things I think should be in the next social security bill that is enacted.

I know what a heavy schedule you have and I will limit my remarks to items which I think deserve special priority.

There seems to be general agreement that there should be an increase in social security benefits. The only questions are how much of an increase and when. For my part, I think that the increase should be as large as possible and as soon as possible. The information that I have indicates that a 15 percent benefit increase about the first of the year is possible. Moreover, I understand that this could be done by using the existing actuarial surplus, the present tax rates, and a modest increase in the tax base.

The 10 percent increase advocated by the President and others would be too little; and the March effective date would be too late. By that time, if present trends continue, the cost of living will be more than 10 percent higher than it was when the benefits were last increased. And if a 10 percent increase is then tied to an automatic cost-of-living provision, we will be in the position of running twice as hard to stay in the same place. I think we can do better than that.

Mr. Chairman, in my opinion, a 10-percent benefit increase next March would be a cruel hoax. I urge you as strongly as I can to recommend a 15-percent benefit increase payable as quickly as the Social Security Administration can get the increased checks out. And I am

sure that I will not be the only one to come before this committee with this suggestion. I have faith in this great committee, Mr. Chairman. I believe that when all the facts are out, you will provide a real increase in benefits rather than just a shadow of an increase.

Also, I am concerned about the way married women are treated under the social security program. Many women who work pay social security taxes and get little or no additional benefits in return. I am told, in fact, that under some circumstances it is possible for a husband and wife, both working, both paying taxes, that a married man whose wife does not work pays, and to get less in benefits than is paid to the couple where the wife never worked. This, I might say, is quite unfair to the working couple. I would hope that in the course of your work on social security amendments you would find it possible to do something to provide more equitable treatment to working married women. I know that the gentlewoman from Michigan, Mrs. Griffiths, is interested in this reform and I hope her enthusiasm can be infectious.

Perhaps the best way to do this would be to base a married couple's benefits on their combined earnings records. I realize that a provision to do it this way would be expensive and that this is probably the main reason why such a provision has not been adopted. I think, though, that we have to look at both sides of the cost issue. Social security taxes have gone up over the years, so that they now represent a significant deduction from a married woman's pay. If we are going to require married women to pay significant social security taxes, we should also provide her with a significant benefit—a benefit that the nonemployed wife will not get. I hope that the committee will give this matter the attention it deserves.

Mr. Chairman, I do not want to take up too much of the committee's time, but I would like to go into one other matter in a very brief way. You will recall that the social security bill that came back from the Senate in 1967 contained a liberal provision for paying disability insurance benefits to blind people. For some reason, the provision was dropped in conference. A similar provision has been introduced in both Houses this year. In the House there are 128 sponsors, including myself, and in the Senate there are 69 sponsors, according to the latest count I have. Inasmuch as the majority of the Senate is backing this provision, I should expect to see it in the bill the Senate sends back to us, even if it is not in the bill we send to them. I think that the provision is a good one. I urge you to include it in the bill that you send to the floor so that the entire House will have an opportunity to vote it up or to vote it down.

Mr. Chairman, I appreciate very much the opportunity to be here today.

I thank you for permitting me to appear.

Mr. BURKE. On behalf of the committee, Congressman Moorhead, we thank you for appearing here. You have made an excellent statement that meets entirely with my personal views.

Are there any questions?

Thank you very much, Congressman.

Mr. MOORHEAD. Thank you, Mr. Chairman.

Mr. BURKE. We have with us today our colleague from Wisconsin, Hon. Clement J. Zablocki. Mr. Zablocki, please step forward and identify yourself for the record.

**STATEMENT OF HON. CLEMENT J. ZABLOCKI, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF WISCONSIN**

Mr. ZABLOCKI. Mr. Chairman and members of the committee, I appreciate this opportunity to present my views on various proposals to amend the Social Security Act which are now pending before the committee. May I also commend the committee for your diligent efforts in scheduling these extensive hearings.

My basic concern at this time relates to the need for an immediate and substantial increase in the present level of social security benefits. This is a matter of paramount importance.

THE NEED FOR AN INCREASE IN SOCIAL SECURITY BENEFITS

The unprecedented prosperity of this country stands in stark contrast to the conditions in which many of our older Americans are living. To a large extent this is a result of the rising prices of this inflationary period. If we in Congress fail to take action now to alleviate these circumstances we must bear the blame for a continuation of the hardships which confront many of our senior citizens.

The statistics are staggering: more than one-third of our 20 million older Americans live in poverty. The situation is getting worse, not better, and the stark reality of these statistics is even more distressing.

The dilemma of one of my constituents, an elderly woman in Milwaukee, illustrates the seriousness of this matter all too well.

The meager savings which this woman and her husband had been able to put away during their working years have been eaten up by inflation. Widowed and alone, she finds her predicament unbearable. The taxes on her small home and other necessary fixed expenses have taken so much of her social security checks that she is literally faced with this choice: to buy food for the mouth or to buy the drugs which her doctor has recommended for the maintenance of her health.

I am personally familiar with many other similar cases of hardship in my own Fourth District of Wisconsin. They are a cause of deep concern to me.

The inflation which affects us all strikes particularly hard at the retired who are trying to make ends meet in the face of alarming increases in prices and taxes. Their fixed incomes and often scant retirement resources are literally stretched to the breaking point by inflation. Many worry constantly about how they will survive the next month.

Truly the carefree "golden years" to which we all look forward do not exist today for the average American. I submit, this is a national disgrace in a country as prosperous as ours.

Having recognized the seriousness of this situation we must take appropriate action to correct it.

In view of the rise in the cost of living in recent years an immediate 15-percent increase in social security benefits is certainly in order. Indeed, even an increase of this amount can hardly be called ample.

Such an increase will not in itself eliminate the hardship which is the lot of so many of our senior citizens. Additional measures will also be necessary. Among them are:

Further reductions in nonessential Federal spending and other measures to curb the inflation which threatens to rob us all of the fruits of our labor.

Additional Federal aid to the States to help finance needed programs and eliminate unreasonably high property tax rates which penalize many senior citizens.

A comprehensive reform of our welfare system which will eliminate existing abuses and make more adequate payments available to those in real need of assistance.

Nonetheless, the needs of our senior citizens are immediate. They certainly warrant immediate action on a significant increase in social security benefits. Therefore, I trust that the committee will expedite an increase in benefits by reporting a separate benefit increase bill before recommending a bill embodying comprehensive changes in the social security and welfare systems.

IMPROVEMENTS IN THE SOCIAL SECURITY SYSTEM

Additional changes in the social security system appear to be necessary in order to make it more equitable for those who have paid social security taxes during their earning years.

I have always favored maintaining the social security program as a self-sustaining, actuarially sound insurance plan. However, if the program is to extend beyond its original concept, it is my firm belief that the resulting increases in the cost of the program should be financed out of general revenues rather than by additional increases in the social security tax.

As you know, the social security earnings limitation is \$1,680 for those under 72 years of age. How unfair it is to penalize older Americans who have the desire and ability to continue working after retirement by an earnings limitation which is less than the poverty level. As I have advocated in previous years, this limitation should be increased to at least \$2,000.

As recommended by the advisory council established by the social security amendments of 1967, medicare protection should be extended to the disabled who are less than 65 years old.

Modifications should be made in the medicare and medicaid programs which will further direct the thrust of these programs at improving the quality of health care in this country and reducing its cost—rather than having the opposite effect. At the same time, benefits for needy persons under these programs should be maintained at adequate levels.

In addition, it is my hope that the committee will give serious consideration to authorizing reduced social security benefits for both men and women who choose to retire at age 60 and to allow women with 30 years of coverage to retire at age 62 with full benefits. These provisions, which are embodied in my bill H.R. 8679, have received strong support from many of my constituents.

WELFARE REFORM

It is apparent that steps must be taken to make our Federal-State welfare program both more efficient and effective, and therefore less costly in relation to its benefits, and more adequate to those who are in

real need of it. President Nixon's welfare proposals should be scrutinized carefully to see if in fact they would accomplish both of these ends.

An important basis for welfare reform is the establishment of national uniform minimum standards and eligibility requirements for welfare payments. H.R. 6635, which I have cosponsored with many of my colleagues in the House, is designed to do this.

Also extremely important in this connection is a continuation and improvement of our efforts to help able-bodied welfare recipients become self-sufficient and productive members of society. Training and job placement programs should be upgraded. The educational facilities of child day care centers where welfare mothers leave their children when they go to work or to receive job training should be improved, as I have proposed along with my colleagues in H.R. 4190.

In addition, the food stamp program should be expanded to become even more effective in eliminating the last vestiges of hunger in our country.

Finally, caution must be exercised to insure that any birth control information which is made available in connection with welfare programs is done on a strictly voluntary basis. Information on all methods of birth control should be available and the rights and consciences of all welfare recipients in this matter must be respected.

SUMMARY

These then are my views on some of the important aspects of social security and welfare reform.

As indicated previously, it is my belief that an immediate and substantial increase in social security benefits is the single most important issue now before the committee. I respectfully urge the committee to act as soon as possible on this matter.

In addition, I trust that the information presented in connection with these hearings will serve as the basis for a comprehensive bill embodying other needed amendments to the Social Security Act.

Thank you.

MR. BURKE. We appreciate your statement. Are there any questions. If not, we thank you for being here today.

We are pleased to have with us today Hon. James M. Hanley, from the State of New York. We welcome you to the committee, sir, and you may proceed as you wish.

STATEMENT OF HON. JAMES M. HANLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

MR. HANLEY. Mr. Chairman, I sincerely wish to commend the committee for considering the issues of social security revision. Those of us who have been calling for such revision were both pleased and disappointed by the President's recent proposals. We were pleased that he had finally decided to move in the direction of badly needed and long overdue increments; we were disappointed that he proposed only a 10-percent increase to take effect next April. As I indicated in a speech on the floor October 6, my mail, and I feel safe in saying the mail of every Member of the House and Senate, is replete with correspondence from social security recipients who have their backs right up against

the wall. Their meager incomes remain stable while their social security checks and their savings are eaten up by inflation. This situation would be unpardonable even if we did not have the funds to carry out an increase in benefits, Mr. Chairman. But we do have the funds and we do not have to increase taxes measurably to make them available. Because of this, any further delay in increases is unconscionable.

I propose, Mr. Chairman, that this committee consider and write into their bill legislation that contains a twofold guarantee: An across-the-board increase of 15 percent and a \$100 a month minimum benefit, effective upon enactment. I have talked to hundreds of recipients in my congressional district, many of whom have been retired for 10, 15, or 20 years and who are trying to get by on \$70 to \$80 a month. And many of them are eking out an existence on even less. They cannot wait until April of 1970 for an increase. They need it now. And they need it desperately. We can do no less.

But, Mr. Chairman, our moral and social obligations to the elderly and the needy of the Nation go further than merely a raise in social security benefits. They should and must include expanded benefits under the program. There are thousands, indeed maybe millions of senior citizens who, while not hospitalized, are nonetheless ailing and require special services and special drugs not now covered by social security. Our moral obligations do not end with the provision of a subsistence allowance only. How can we as a nation say that we are meeting our responsibility to the old when hundreds of thousands of them live on a mere pittance, when circumstances force them to spend a larger than normal share of their budgets on drugs and home care, and when the essentials of life, which are theirs as a right, are denied them because of the high cost of living.

I propose that the benefits not only be increased but expanded to include prescription drugs for nonhospitalized but chronically ailing social security beneficiaries and that home-care costs be borne in part by the social security program. Because of the crowded hospital and nursing home situation today, many of our senior citizens are not receiving adequate and proper treatment. The present structure does not afford them proper drug and home care. There is no excuse for allowing this deplorable situation to continue. I endorse and support the proposal advanced by former Health, Education, and Welfare Secretary Wilbur Cohen whereby chronically ailing social security recipients would have to pay only the first dollar for each drug and the remainder would be paid out of our OASDI funds. I endorse also an expanded program of home care for ailing recipients who need special services but who are neither bedridden nor hospital bound. We must pursue these goals vigorously and at once if we are to afford these millions of Americans, who have already given so much to our society and its economy, an opportunity to live out their lives in decency.

Mr. Chairman, there is yet another side of the social security program which is extremely important, but which seems to receive all too little attention, either in the media or here in this committee. We all know that retirement brings with it a reduction of earnings. This is the initial reason the social security program was established over 30 years ago. What is not so apparent, however, but what is equally significant is the fact that thousands of retirees who could continue to make important contributions to our society are denied that right by

the ridiculous limits placed on outside income by the present social security retirement test.

We all know that a part-time job can be not only financially rewarding for an older person, but that it can be therapeutically and psychologically invigorating as well. There is nothing so justifiably proud as a man or woman who is accomplishing something and feels needed. Yet the shameful lag on the part of Congress in not correcting and updating the retirement test denies that sense of contribution to thousands of our senior citizens.

Under the present system a recipient may earn up to \$1,680, plus \$1,200 a year without losing any benefits. I propose that this be raised to a minimum of \$2,000, with perhaps a sliding cost-of-living scale so that those who can and those who want to supplement their incomes may do so without suffering unduly. And, collaterally, I propose that the formula which would require a \$1 deduction from benefits for every dollar earned over the new level of \$3,200 be restructured to require a \$1 deduction for every \$3 earned. The administration has suggested a \$1,800 cutoff and a \$1 loss for every \$2 earned over the \$3,000, but I do not feel this is adequate.

We are literally throwing away an incalculable asset in the talents and wisdom of millions of our senior citizens who have chosen to withdraw from the scene rather than lose their hard-earned benefits. This, likewise, is an intolerable situation which demands immediate attention.

In conclusion, Mr. Chairman, I would like to urge upon you and the other members of this committee that these are not unreasonable goals; nor are they unattainable. We who are reaping the fruits of a prosperous and dynamic America owe this to the tireless dedication of the generation that preceded us.

Again, my appreciation for your courtesy in allowing me to present these thoughts and proposals.

Mr. BURKE. Thank you for your fine statement. Are there any questions anyone would like to ask? There are none. Thank you again, sir.

Our next witness is Hon. Harley O. Staggers from the State of West Virginia. We are certainly glad to have you with us.

STATEMENT OF HON. HARLEY O. STAGGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. STAGGERS. Thank you for your generous allotment of time in which to present my views on the subject of social security amendments, presently before your committee.

It is my conviction that any increase in social security benefits we may allow should be made effective as of January 1, 1970, or earlier. A delay until spring 1970 would inflict intolerable hardship on millions of old people who have been reduced by the rising cost of living to a condition little better than that which they faced when the social security system was first put into operation.

The increase in benefits which I would propose at this time is 15-percent across the board, with a minimum of \$90 per month.

I do not defend this increase as being adequate. It is grossly inadequate. The benefits provided by the original social security law, when matched with costs of living, were measurably superior to those that

could be offered by any increase that would have a chance of congressional approval at this time.

A new study made by the U.S. Department of Labor shows a "minimum budget" of about \$3,000 for a retired couple, running somewhat higher in the urban Northeast and Far West, and a little lower in the rural South. This represents an absolute minimum for health and housing, leaving nothing for recreation or self-improvement. A "moderate comfort" budget for the same couple calls for \$6,600. And this, in turn, corresponds to a low-average income for the same couple before retirement.

Similar studies by the Department of Labor show that the wage hike in 1969 averaged 8 percent, and in 1968, 6.6 percent. The two wage increases amount to as much as is proposed, percentage-wise, for the new social security benefits. Meanwhile, the cost of living has increased about 9 percent in the last 2 years, and is presently rising by about one-half of 1 percent per month, 6 percent for a year.

The cost of supplementary medical insurance under medicare has been raised already. Many—perhaps most—beneficiaries of social security are forced to carry health insurance in addition to medicare. The cost of the larger group health insurance plans is being increased by a figure running from 20 to 30 percent. These two increases alone will absorb a major part of the increase in benefits for average beneficiaries.

Federal administrative departments are presently engaged in an effort to reduce the number of jobs. Older employees were offered a bonus in benefits if they would retire by October 31, 1969. It was expected that a large number would take advantage of the offer. It is now reported that a large number did apply for retirement, but upon computing the income tax costs involved, and the relatively small increase in benefits, they could not afford to retire. They withdrew their retirement applications, with the result that the various departments will not reduce their personnel as expected.

Recent slowdowns in industry suggest the possibility of employment reduction in private industry also. Jobs are likely to become scarcer. Older employees will be urged to retire. Perhaps they will be forced to retire. The proposed increase in social security will be poor compensation for the loss of a good job.

In a rapidly changing society, adjustment of social security benefits should not be left to the whims of a political minded Congress. It should be made to conform to changes in cost of living, as are many wage contracts. Social security beneficiaries are not organized. They have no effective lobby to represent them. I propose that benefits be subject to semiannual revision, in line with the cost-of-living index.

Some adjustments must obviously be made in payments into the social security system by both employers and employees. I shall support any increase in percentage of wages paid in, and also in the amount on which the payments are based, provided these increases are determined as necessary by the social security system.

Mr. Chairman, I consider it imperative that improvements in the social security system be made before adjournment of this session of Congress. Our integrity is at stake. We are committed to the increase. The changes which I have suggested are the least which could be offered, in my opinion.

Mr. BURKE. Does that complete your statement? Are there any questions? I hear none. Thank you for bringing us your views.

Mr. STAGGERS. Thank you, sir.

Mr. BURKE. Our next witness is Hon. Ed Foreman from New Mexico.

**STATEMENT OF HON. ED FOREMAN, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF NEW MEXICO**

Mr. FOREMAN. Mr. Chairman, I want to thank the members of the committee for the opportunity to present the facts relating to H.R. 9231, a bill which I introduced proposing a technical provision, to be included in consideration of social security legislation, to permit the State of New Mexico to revise its agreement, entered into under section 218 of the Social Security Act, so as to extend under section 218 of the Social Security Act, so as to extend social security coverage to certain hospital employees in the State.

If this provision is approved, it will extend to approximately 45 employees of the Socorro County General Hospital in New Mexico the privilege of obtaining social security coverage. Without enactment of the provision, these employees will continue without eligibility for either Federal or State coverage, and will continue to be denied the right to such coverage which already has been extended to employees of other similar hospital facilities in New Mexico.

The situation was created by unusual circumstances which began with a misunderstanding within the State as to whether employees of the Socorro County General Hospital were under the New Mexico Public Employees Retirement Association. At that time, it was held that the employees were under the State system, and the management of the hospital took action which removed the employees from the system under the assumption that the employees would then be eligible to obtain social security coverage which they had indicated they wanted.

However, provisions of the Social Security Act created an obstacle because the positions of the hospital employees had been under a State system for a period of time.

None of the employees of the Socorro County General Hospital are still members of the New Mexico Public Employees Retirement Association. For this reason, it is not possible to cover hospital employees under the coverage provisions applying to retirement system groups, as there is no employee eligible to vote in the coverage referendum required by Federal law before coverage may be extended to a retirement system coverage group.

According to information I received from the Social Security Administration in my own examination of the circumstances in this matter, in certain situations, persons who, for social security coverage purposes, are in positions covered under a retirement system but are not eligible to become members of such system, may be covered as a part of a group made up primarily of persons not in positions under a retirement system. However, as the hospital employees of the Socorro Hospital in the past have been considered by the State to be members of the Public Employees Retirement Association, under the provisions of the Social Security Act, they cannot be covered under this procedure.

Enactment of the provisions of the bill which I introduced, H.R.

9231, would permit the State of New Mexico to modify its coverage agreement with the Secretary of HEW to provide coverage for the employees of Socorro County General Hospital. One modification would be necessary in the language of the bill—the time limitation in the proposed provision. The date closing the period for modification of the State's agreement should be extended to January 1, 1971 instead of January 1, 1970, the date within the bill when introduced earlier this year.

I respectfully request the favorable consideration by the members of the committee of this provision which will extend the privilege of social security coverage to the employees of a New Mexico hospital facility who, due to unusual circumstances beyond their control, cannot otherwise obtain the coverage to which they should be entitled.

Mr. BURKE. Are there any questions?

Thank you so much, Mr. Foreman, for coming to the committee.

Mr. FOREMAN. Thank you.

Mr. BURKE. The next witness is Hon. John T. Myers, a Member of Congress from the State of Indiana. You may come forward, Mr. Myers, and proceed.

STATEMENT OF HON. JOHN T. MYERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. MYERS. Mr. Chairman, I favor legislation which would grant an immediate increase in social security benefits and reforms linking future increases to the cost of living.

While my bill, H.R. 9653, is directed principally at the question of future increases, I do want to emphasize that those now depending on social security have been hardest hit by the inflationary trend and need an immediate increase.

I urge this committee to act swiftly. We must keep faith with the more than 24 million Americans who months ago were led to believe they could expect speedy approval of increases in social security benefits.

It is a matter of simple justice that older Americans be protected against the continuing inflation. It can be done if this committee will act now to divorce social security from politics and grant these citizens the assistance many of them need.

These slighted members of our society are caught in today's economic trap. On one side they are confronted with soaring living costs and on the other side they are stymied by fixed incomes, social security payments that do not come near meeting the bare minimum of expenses, and social security regulations which prevent them from earning more than \$1,680 per year in outside income.

I hope you will give serious consideration to the provisions in H.R. 9653 which would increase the limitation on earnings for social security recipients to \$3,000 and increase survivor benefits to 150 percent of the recipients pension.

I appreciate the fact that changes do not come overnight and that our country is in the midst of a very serious and critical economic crisis. Yet, our elderly citizens are entitled to the guarantee of a brighter day, not because they, like some, demand it, but because they have earned their right to this future.

Immediate approval of this legislation is imperative if we are to meet the needs of these Americans who already have done more than their fair share for their country.

Mr. BURKE. Are there any questions of Mr. Myers? Thank you, sir, for giving us your views here today.

Mr. MYERS. Thank you.

Mr. BURKE. Our next witness is Mr. Melvin A. Glasser.

We welcome you to the committee, Mr. Glasser, and note that you are the Director of Social Security, United Automobile Workers of America, and you come here very well qualified.

STATEMENT OF MELVIN A. GLASSER, DIRECTOR OF SOCIAL SECURITY, UNITED AUTOMOBILE WORKERS OF AMERICA; ACCOMPANIED BY JACOB HURWITZ

Mr. GLASSER. Thank you.

Mr. BURKE. You may proceed.

The CHAIRMAN. Mr. Glasser has been before the committee many times in the past and he has been helpful to the committee.

Mr. GLASSER. Thank you, and if I may be personal and express pleasure to you, Congressman Mills, that you are back with us. I trust you will remain well.

May I have the privilege of having with me my associate. Mr. Jacob Hurwitz of the UAW, who works with me?

Mr. BURKE. We are quite happy to have him.

Mr. GLASSER. Members of the committee, I have filed a rather extensive statement which I do not intend to read and which is available to the members of the committee. I would like to comment relatively briefly on three main aspects of the considerations before this committee and my comments will deal primarily with the Family Assistance Act proposal, with medicare and medicaid.

I will not be commenting on the cash benefits proposals since the Alliance for Labor Action is scheduled to testify next week and we wish to associate ourselves with their views on this matter and will not comment on them this morning at all.

The first point I would like to put before the committee is that we have about 1,600,000 members. We represent over 5 million people, including the families of our members. The composition of our union has changed in that close to 40 percent of our members are now under the age of 30, so that we have a very young union, and it has been a source of great interest to us that there has been tremendous interest in the Social Security Act and its amendments among the younger members. We expect it among the older members. And the views that I represent here today are the views of our members, young and old, and their continuing interest in discussions all over the country.

With regard to the Family Assistance Act, our union takes the view that this is a very good and progressive forward step in terms of the principle of establishing a federally financed floor for the income of welfare recipients. We see this as a first step toward an adequate national minimum income standard.

We like the idea of having basic eligibility standards on a uniform basis and we like the idea of incentives for welfare recipients to work and increase their incomes, though we are concerned that there be

established more effective standards so that throughout and among the States the training requirements can be more uniformly developed.

Having said this and having said that we endorse the principles, because we think it took courage and imagination for the administration to make this proposal, we believe the act would be strengthened by several additional measures. First, additional Federal assistance should be made available to finance welfare benefits substantially beyond the \$1,600 federally financed minimum. We believe the States should be required to supplement the minimum by at least 50 percent of the present benefit.

We note the proposed Federal standard is already equaled or exceeded in 40 States and is more than \$400 below the national average welfare benefit in 1968, so that even when supplemented by food stamps many people will fall below that level. The main thing that is of concern to our members, most of whom live in the cities, is that the level of benefits proposed in this legislation will barely touch the residents of the urban ghettos where we are most concerned about the crisis that has developed and is developing.

The second point that we would like to make is that the act should be modified as we propose to require States to provide welfare benefits that meet the States' own current definitions of need. In 27 States, as you gentlemen know, last year that was not the case.

We don't think it makes sense that more than half of the States continue not to meet their own definitions of need.

We think these fiscal restrictions are creating undue hardships and we hope that will be corrected. We also believe that the general assistance recipients should be included in the proposal, as they are not now included.

And then we come to a matter that has been troubling us very considerably, gentlemen; that is the proposal to bring several million working poor into the welfare system. I must say to you that we have had many discussions in our union about this because we recognize that there are undoubtedly several million people who work all year long and still don't have enough income to support their families. This is a very unfortunate situation. We want to see it changed.

We have our doubts about the present proposal, however, because we question the soundness of bringing into the welfare program more people, in such large numbers, who are the working poor.

We are also concerned, and deeply concerned, lest this action freeze present wage levels, and, in effect, subsidize the sweatshop employer. Obviously, nobody wants to do that.

We believe this may be the result and we would suggest as an alternate proposal that the Congress which give consideration to increasing the minimum wage to \$2 and to doing something about starting a family allowance system which would bring large families up to par and above the poverty level. But we have grave doubts about the soundness of bringing them into a welfare system which, we are trying gradually to whittle down and reform.

Our fifth and final point on welfare is that we have great concern over the requirement that mothers of school-age children be declared ineligible if they refuse to accept work or training. We think that requirement should be eliminated. We know from our experience that many of the mothers do wish to work. We know, for example,

that in New York City the lack of day-care shelters and training opportunities is keeping mothers from working. We know from our experience in the union that there are mothers who move in and out of the work force because of the problems of caring for their children. We believe that a poor mother ought to have the same right as any other mother to make a determination as to whether she is needed more at home with her school-age children than she is at work. And I must say, as Congressman Mills knows, I have worked for many years on the problems of juvenile delinquency, and I am concerned lest 10 years from now some of us have to sit across the table this way and worry about a new problem of juvenile delinquents, of kids who were brought up without parental supervision at home and who are therefore facing the problems that we face so seriously in delinquency today.

So, with these major changes, I would suggest we support in principle the welfare proposal and hope they might be modified.

If I may go on to medicare, which is a program that our union worked very hard to support, and, to have adopted. We worked very closely with the members of this committee and with others to bring it about and we are pleased with it. At the same time, we see it as contributing to the health care crisis which this country clearly is facing. We have several proposals to make, and I will cover them very briefly. We think our proposals will help deal with the situation.

First, we believe that the cost of out-of-hospital prescription drugs should be covered. I will not go into this in great detail. You have heard of arguments. Let me only say from the point of view of our union, we now have a benefit covering the cost of prescribed drugs for our actively employed members and their families, with certain restrictions. The program became operative only this past October 1. It is working exceedingly well. It has gotten exceedingly good response, and we have had a similar benefit operating for our members in Canada for the past 5 years.

Interestingly enough, you may find it useful to know that in our Canadian experience for our older members, 50 percent of the drug costs of people past 65 are spent on 10 percent of the people, a fact which indicates crudely the nature of the need, particularly for those with chronic and long-term illness.

We believe it is time to provide a drug benefit under medicare.

We believe, too, as we have testified before, that medicare coverage for disabled persons receiving cash insurance benefits under the social security system should now be included. We know that the Congress deferred action in 1967 until an advisory council could study the problem. You have the recommendations of the advisory council which are favorable. We hope the Congress will act affirmatively.

We would also like to see elimination of medicare patient payments but at the least, gentlemen, we are urging that the payments be frozen now and not be increased as it is proposed on the first of the year. I refer particularly to the hospital payments and the nursing home payments. Gentlemen, these increases result from cost inflation but paying additional money out of the incomes of social security recipients who have fixed incomes constitutes a very severe added hardship.

We also know among our own retirees—we have 225,000 of them who are very well organized, so we have good contact with them—

that numbers of them have not participated in part B of medicare, despite our strenuous efforts to persuade them of its value and despite the fact that our members are more advantaged in terms of income than are most persons receiving social security benefits. We find it very hard to deal with this because they say that the \$4 a month, or \$8 if there is a couple—soon to be further increased—is a further drain on their incomes that they can't support. We believe that further increasing the premiums is shortsighted.

We are opposed to it. We are deeply concerned that both the increase in patient payments and in part B premiums will have an adverse effect on the program.

Furthermore, we believe that parts B and A should be now merged as has been proposed before to this committee. We believe that the premiums should be dropped and that in their place we should provide general revenue contributions and make this an integrated program, as I think most people believe now it should be.

And then we want to make a comment on the assignment system. The failure to require assignment has had a very adverse effect not only on the OASDI recipients, but on everyone else who is in the medical care system, because it has brought about increasing physician fees. It has created great confusion. It has added to the cost of the program. It has also added to the cost of medicaid because it has increased the level of medical prices in the general community. After very careful consideration and long discussions with our members, we wish to urge that the committee give serious consideration to requiring assignment of all physicians in the system.

We recognize that one-third of physicians are now not accepting assignments. We recognize there is a calculated risk in requiring assignment in that we may lose some physician participation. We believe that the American physicians are sufficiently oriented toward service so that practically all of them will come in. We think it is a constructive measure and urge that it be considered.

And, finally, we would like to urge that the Secretary be encouraged to initiate projects using prepaid group practice and other organized programs. When I had the privilege of testifying before this committee a year ago, I presented evidence, which I shall not burden you with again, indicating that very substantial savings are effected through such programs. We believe that encouraging the purveyors to make available services on a capitation basis could provide another means of effecting savings and if the committee should wish I can submit evidence to that effect.

Now, a few words on medicaid, gentlemen.

Mr. BURKE. We would like you to submit that evidence if you would care to.

Mr. GLASSER. Yes, sir, I will be glad to.

Mr. BURKE. We will hold the record open for that.

(The following letter was received by the committee:)

SOLIDARITY HOUSE,
Detroit, Mich., November 25, 1969.

Hon. JAMES A. BURKE,
Ways and Means Committee,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN BURKE: At the time of my appearance on behalf of the UAW before the Ways and Means Committee at the recently concluded hearings on social security legislation, I referred in discussing Medicare, to the substantial economies, in the use of health care funds, that are attainable through comprehensive group practice medical care plans.

You expressed an interest in seeing supporting evidence for my statement about group practice and indicated you would hold open the record so that it might be included. Accordingly, I would like to add the following comments:

It is well established that prepaid group practice prepayment plans, such as OHA-Detroit, HIP in New York, and Kaiser on the West Coast, have significantly lower rates of hospital admissions and lower surgical frequency rates when compared with comparable insurance groups under fee-for-service medicine. The following data clearly reflect the impact on costs of the controls used by group practice groups participating as compared to nonprofit Blue Cross-Blue Shield or commercial insurance plans.

HOSPITAL-SURGICAL UTILIZATION STATISTICS

A. Comparative hospital utilization rates

1. PLAN STATISTICS

	Annual days of hospital care (excluding newborns) per 1,000 members		
	1966	1967	1968
(a) CHA—Metropolitan hospital only.....	504	506	465
(b) CHA—All facilities.....	621	581	1,544
(c) Michigan Blue Cross.....	1,266	1,121	1,066

2. FEDERAL EMPLOYEES HEALTH PROGRAMS (BOTH OPTIONS)

	November 1963 to October 1964	November 1964 to December 1965	January to December 1966
(a) Blue Cross-Blue Shield USA.....	881	924	876
(b) Indemnity benefit plans.....	880	945	884
(c) Group practice plans.....	451	415	408

B. Comparative inhospital surgical procedure rates

1. FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAMS (BOTH OPTIONS)

	Rate per 1,000 members January to December 1966	
	Blue Shield USA	Group practice
(a) All procedures.....	73.0	31.0
(1) Tonsillectomy and/or adenoidectomy.....	8.4	1.9
(2) Female surgery.....	8.8	4.5
(3) Appendectomy.....	2.2	1.1
(4) Cholecystectomy.....	1.9	1.4

¹ Estimated.

SOURCES

A.1. CHA Research & Statistics Division; Michigan Hospital Service, Annual Report, 1968.

A.2.-B.1. The Federal Employees Health Benefits Program 6th Term Coverage & Utilization by Perrott & Chase, Special Supplement to Group Health & Welfare News, October, 1968.

These data clearly indicate that prepaid group practice plans in Detroit and across the country effect savings of 50% or better in the number of hospital days used for their members as compared with similar groups under Blue Cross or indemnity benefit programs. In this connection it should be pointed out that the FEP report for 1966 includes an average of more than 7.1 million persons including employees, annuitants and dependents. Of this number there were more than 300,000 persons enrolled in group practice plans. The Federal Employees Health Benefits Program data was taken directly from the officially compiled U.S. Civil Service Commission reports issued annually in connection with the operation of the Program.

Of equal importance in considering possible program economies and safeguards to qualify is the question raised by Chart B above which shows significantly fewer surgical procedures for federal employees covered by the group practice plans than for those covered by Blue Shield. The rates for differences in tonsillectomies, female surgeries, appendectomies and cholecystectomies show almost two-and-a-half times more surgical procedures in Blue Shield as compared with group practice. It is hardly likely that this large a difference is due to chance occurrences. Furthermore, it is well known that another factor in the burgeoning costs in the medical care of this country is attributable to the hospitalization of many patients for procedures which might more properly be done out of the hospital.

The experience of group practice plans suggests that more economical use of hospital facilities is possible and that there may be unnecessary surgery in solo practice medicine as compared to group practice.

Sincerely yours,

MELVIN A. GLASSER,
Director, Social Security Department.

MR. GLASSER. The evidence will indicate that the hospital days for the recipient of care in prepaid plans on a capitation basis are roughly one-half of that of matched groups in the general population. At the rate of \$60 to \$70 to \$80 a day, when you are talking about 450 hospital days per thousand persons versus a rate in the neighborhood of 900 days per thousand persons, then you are talking about a great deal of money.

A few words about medicaid and my formal presentation is at an end.

Medicaid either can be covered, gentlemen, in a few words or in a few days and I propose only to do it in a few words. While we subscribe to the objective of medicaid to assure the poor access to adequate health care, we doubt seriously that the program can be made to perform adequately. The need, however, is very great and we have great problems in figuring out a method of improving the system because, basically, we believe it needs to be replaced.

We think medicaid is not working at all well. We think it is poorly constructed and administered. We think it is not achieving its objectives when only 11 million out of 35 million users are covered. We think there is something basically wrong when 45 percent of the medicaid payments are going to people past the age of 65, an indication that medicaid is patching the dikes in medicare. We begin to wonder whether it is doing the job that it should be.

We get very worried in the States that are facing understandable crises in finances when cutbacks are made at the expense of the recipients, rather than those who are making the money out of the system.

We think there are real problems.

The first of our very few recommendations on medicaid go to the implementation of an effective utilization system. We can say to you gentlemen, from our experience in the 34 States where we have

members, that the development of an effective utilization and cost control, that system is the highest priority.

We think such a system offers the greatest opportunity for saving money and for improving service. We believe that the Federal Government ought to develop a model system of utilization review. We believe that system should be made available to the States and, if necessary, a subsidy for its administration be given. We believe that there should be peer review, and if that fails, the States themselves should take on the responsibility for review. We believe that there are tens of millions of dollars being needlessly spent, and I will not take the time of this committee to cite the evidence which I am sure you have had in very rich amount, including yesterday's New York Times story "City Reports 207 Practitioners Cheated or Stinted on Medicaid."

We are not saying to you gentlemen that the purveyors of services are all dishonest. That is not the situation. We are saying that in the way in which the system is constructed and in the absence of effective utilization review and cost control, waste and inefficiency are inevitable. We believe there is a sound way of controlling costs and services, and our written testimony has spelled this out in more detail.

The second of these recommendations is that we would also like to see some money earmarked, perhaps 5 percent, from medicaid funds, for improved delivery of services.

In the present chaotic, disorganized way in which the program operates, money is spent on episodic illnesses. No attempt is made to preserve the health of these people or to improve it in an organized way. What is even worse, this failure to provide coordinated services adds greatly to costs.

One quick illustration. On the west coast in the Kaiser Portland plan a contract was made with OEO to provide for several thousand poor people, comprehensive care on a capitation basis. In the first year, this contract with OEO was estimated to have a cost of twice the average cost of providing care to all the rest of the population. In fact, it turned out initially, to cost about 12 percent more, and in the second year the cost is proving to be parallel with and not different from that of the rest of the population. We believe this is only one illustration of the way in which comprehensive care can be provided, and be provided more effectively if HEW were encouraged and if there were money available to encourage the States to undertake this kind of program.

We are concerned about the quality of care under medicaid. We are deeply concerned about it. We have numerous reports from our people about shoddy service, about second-rate treatment, et cetera, et cetera. We would like, therefore, to recommend for your consideration four steps which we think would help immeasurably as a start.

One very simple thing. We believe there ought to be a requirement that payment can be made only in accredited hospitals. The accreditation standards of the Joint Commission on Accreditation, gentlemen, are not high. They are really quite low. We would like to see them raised.

But payments are being made, and too many hospitals that aren't even that good, and there is substantial evidence that care is inferior when it is given in inferior hospitals.

Secondly, there is considerable testimony from the medical profession that morbidity and mortality are substantially reduced when major surgery is performed only by board-qualified or board-eligible surgeons. It is a simple requirement, gentlemen. Except for emergencies and in a few isolated areas in the States, this requirement could be implemented tomorrow. It could be implemented and, at the same time, substantially improve the quality of care offered in surgery.

Third, we are suggesting that there be a requirement that physicians who are to be paid under medicaid produce evidence—there are ways of doing this—that they are keeping up professionally, that they in fact have done something about keeping up with the great advances in science in recent years.

Fourthly, that in the physician's offices there be required standards of cleanliness, sanitation and hygiene to indicate a reasonable concern good patient care. There is substantial evidence, for example, in big cities such as New York and Chicago that is not always the case, and we would like to urge that standards of sanitation be enforced.

We would also like to recommend that there be simplified, advance certification procedures for medicaid, such as are being tried in welfare, so that a person doesn't have to wait until he becomes ill and then go through the procedures. What could be done would be simply to see that an individual could be certified as eligible, carry a card which is good for, let us say, 90 days, and then if he should become ill, immediately receive needed care.

Our final point deals with consumer representation. The intent of the Congress, I know, was that there be consumer participation and representation in medicaid at both the national level and in the States. Our experience is that there is not such a situation. Beyond that, we go on to say we can't even find out what the situation is, there is so little knowledge of it.

We believe that if the programs are to be responsive to the needs of the people for whom they are designed, the intent of Congress ought to be carried out as it is not now being carried out.

So gentlemen, what we are saying is we support in principle the proposed welfare amendments, with those changes we have indicated. We have recommended changes to strengthen medicare. We have questions about the validity of the way in which medicaid is operating and we have suggested some changes which we think would put some cost and quality controls in.

Thank you for your courtesy.

(The statement referred to follows:)

STATEMENT OF MELVIN A. GLASSER

DIRECTOR, SOCIAL SECURITY DEPARTMENT,

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND
AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW)

My name is Melvin A. Glasser. I am appearing on behalf of the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW) in my capacity as Director, Social Security Department.

I am pleased to have the opportunity to appear before your Committee to present the views of UAW on proposed legislation relating to the welfare titles of the Social Security Act, particularly "The Family Assistance Act of 1969" (H. R. 14173) and on proposals dealing with Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act.

My statement is divided into three parts. The first deals with the need for substantial revisions and improvements to the present welfare provisions of the Social Security Act. The second part includes our recommendations for improving performance, benefits and coverage under Medicare in the context of a national crisis affecting health care. The third is a review of Medicaid, along with specific suggestions to illustrate the kinds of reforms that, in our view, are essential if that program is to operate successfully.

(Summary)

Statement by Melvin A. Glasser, Director, Social Security Department, International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW) Before the Ways and Means Committee of the U. S. House of Representatives Concerning "The Family Assistance Act of 1969" (H. R. 14173) and Proposals Relating to Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act.

I. Public Welfare

The UAW shares the nation's concern over the inadequacies of our present welfare system. While an assured minimum income for all must be our ultimate goal, the "Family Assistance Act of 1969" (H. R. 14173) includes many important reforms in the way in which we assist the disadvantaged.

The UAW endorses the underlying concepts of the following major improvements proposed in the Family Assistance Act:

- . The establishment of a Federally financed floor to the income of welfare recipients, as a first step toward an adequate national minimum income standard which all Americans must be guaranteed.
- . The establishment of uniform national basic eligibility standards in a family assistance program.
- . The establishment of incentives for welfare recipients to work and increase their incomes.

Variations in work and training requirements as well as work incentives that would undermine the spirit and purpose of the proposed legislation should be prohibited explicitly. In addition, the UAW urges that the following changes and additions recommended in this statement be incorporated into legislation implementing the Administration's essentially praiseworthy program.

1. Additional Federal assistance should be made available to finance welfare benefits substantially beyond the proposed \$1600 Federally financed minimum. States should be required to supplement the Federal minimum by at least 50% of the present state benefit.

2. To the extent that the above proposal requires the state to spend more than 50% of its current total welfare expenditures, the Federal government should contribute 25% of such cost incurred. In no case should the proposed welfare program result in reduced benefits or restrict Medicaid eligibility for all groups presently receiving public assistance or Medicaid.
3. The "Family Assistance Act" should be modified to require states to provide welfare benefits that meet their own current definitions of need. Such standards should be regularly revised to reflect rising costs and improved general standards of living.
4. The present food stamp program should be expanded significantly and placed in the Department of Health, Education and Welfare.
5. General assistance recipients should receive aid on the same basis as Family Assistance beneficiaries, at a benefit level sufficient to maintain decency and dignity.
6. Categorical assistance programs should provide a minimum benefit of at least \$100 per month, plus additional allowances for any of the recipient's family members who could not reasonably be expected to work.
7. The establishment of a minimum benefit of \$100 per month plus a 50% increase in all other benefits under Social Security would solve a significant portion of the national poverty problem.
8. The elimination of poverty among the working poor requires establishment of a minimum wage of at least \$2 per hour, supplemented by a realistic family allowance system and an improved Unemployment Compensation system with national standards.
9. The "Family Assistance Act" should be amended to assure the availability of productive jobs after training. The Administration needs carefully to reexamine its policy of undertaking inflation control through measures which have already dangerously increased unemployment.

10. The requirement that mothers of school-age children become ineligible if they refuse to accept work or training, should be eliminated from the family assistance plan.
11. Urgently needed funds and loan guarantees for the construction of new day care facilities should be provided under the "Family Assistance Act. "

II. Medicare -- Title XVIII

The passage and implementation of Title XVIII of the Social Security Act (Medicare) rank near the top of social and political achievements of recent U. S. history. This legislation is a milestone embodying in public policy the idea that access to modern health services is a basic human right.

As significant and valuable as Medicare is, it cannot be isolated from the massive health care crisis affecting all Americans. We in the UAW believe that the existing health care "non-system" in America today must be replaced with a comprehensive, universal program of national health insurance tied to the Social Security system. Ultimately, Medicare must be integrated into such a system. The immediate issue, however, is to provide relief from some of the present difficulties of Medicare, correct some of its deficiencies and gaps in coverage and improve its effectiveness.

For those purposes, we propose the following substantive amendments to the Medicare program.

1. Include Medicare coverage for the cost of prescription drugs used outside the hospital.
2. Provide Medicare coverage for disabled persons receiving cash insurance benefits under the Social Security system.
3. Provide Medicare coverage for other beneficiaries receiving monthly cash Social Security benefits, including workers retired before age 65, and dependent and survivor beneficiaries.
- 4(a). Eliminate deductible and coinsurance provisions currently applicable to both Parts A and B of Medicare and pay the entire reasonable cost of services made available under Part B.
- 4(b). In the event that considerations of "economy" dictate retention of patient payments, freeze them at current levels.
5. Liberalize Medicare time and dollar limitations on services covered so as to provide general hospital care for as long as needed and skilled nursing home care for up to 730 days per spell of illness and to repeal the special limitations applicable to mental illness.

6. Repeal the separate enrollment and coverage provisions of Part B and apply those of Part A to medical benefits.
7. Repeal the monthly premium now required for Part B and substitute payroll contributions and general revenues to pay for medical benefits.
8. Apply a price "freeze" to hospitals and extended care facilities until new, more satisfactory reimbursement formulas can be instituted.
9. Provide payment for physician services only in cases where the physician accepts assignment.
10. Review the "reasonable" cost system for determining reimbursement of physicians with a view towards eliminating those features of the system causing price inflation.
11. Develop a model federal system for use by state agencies to administer Medicare, so that in time Blue Cross and Blue Shield plans and commercial insurance carriers would be replaced in their respective capacities as fiscal intermediaries and fiscal agents by state Departments of Health acting in the role of administrative agents.
12. Direct the Secretary of Health, Education and Welfare to initiate a series of projects using group practice plans and other organized care programs and new reimbursement systems.
13. Direct the National Medical Review Committee to undertake review programs aimed at uncovering problems of overservicing and provision of unjustifiable levels of care, and at attaining acceptable standards of quality and performance.

III. Medicaid -- Title XIX

Title XIX of the Social Security Act (Medicaid) represents a sincere effort to correct the inadequacies, indignities and poor quality of "welfare medicine" as we have known it in the United States. In this legislation, Congress undertook the obligation to assure financial backing to the states for the purpose of developing a consolidated, improved program of medical assistance for all needy persons.

Medicaid, however, has so far failed to remove the stigma of "welfare medicine" and is contributing to the alarming rate of increase in national health care costs. In addition, Medicaid still provides service for not more than a third of the persons it was originally expected to reach. Equally damaging have been widespread reports of abuse, inadequate care and ineffective control and development of the program.

While Medicaid's problems have evoked some constructive countermeasures, the overall response has been to impose new restrictions on eligibility and further curtail the already inadequate services.

"Welfare medicine" has no place in the American health care system. Pending the development of a comprehensive national health insurance system which will replace Medicaid, a variety of efforts are required to improve the appropriateness and quality of care provided and to achieve a workable degree of control and direction in widely varying state programs. Toward this end, the UAW recommends the following measures:

1. State implementation of uniform, mandatory "effectiveness systems" based on a federal model, with federal sharing of administrative costs involved.
2. Earmarked federal non-matching and increased federal matching funds for improved organization and delivery of health services.
3. Federal experiments to develop incentive reimbursement payment methods to providers of service.
4. Increased federal support for construction and renovation of neighborhood facilities to provide

ambulatory primary medical services.

5. Federal assistance to improve state standard setting, certification and consultative services.
6. Introduction, by means of special payment policies, of standards to assure reasonable quality of services under Medicaid.
7. Improved access to coverage for potential recipients of Medicaid through simplified certification procedures.
8. Strengthening and enforcing the present requirement for consumer representation on state advisory bodies.

PUBLIC WELFARE, MEDICARE - TITLE XVIII
AND MEDICAID - TITLE XIX

The present hearings of the Ways and Means Committee cover a particularly broad and significant range of subject matter. The UAW is vitally concerned with that entire range, but in the interests of conserving the time of the Committee and reducing the total volume of testimony, we wish now to associate the UAW with the views that will be presented to the Committee on November 12th in behalf of the Alliance for Labor Action on the Old Age, Survivors' and Disability Insurance Program and Health Care Programs.

PUBLIC WELFARE

We in the UAW share the public's growing concern over the way in which the public welfare system in this country is operating.

In the absence of an assured minimum income for all Americans, which must be our ultimate goal, the recommendations embodied in the "Family Assistance Act of 1969" (H.R. 14173) include many sound and long-needed changes in the way in which we now provide assistance to the disadvantaged.

The Bill's proposals are of major importance for they represent the beginning of a Federal financial commitment to revise America's welfare system. Today, more than ever, public assistance is clearly a national rather than a state, local, or strictly individual problem. As a nation, we can no longer afford a welfare system which, in the words of the National Advisory Commission on Civil Disorders, "is designed to save money instead of people, and tragically ends up doing neither".

The UAW is deeply concerned about the need for meaningful reforms in welfare, health, education, housing and related programs, more quickly to bring the alienated into the mainstream of our society. Accordingly, we endorse and support the underlying concepts of the following welfare improvements proposed in the "Family Assistance Act":

The provision for the establishment of a federally financed floor to the income of those eligible for public welfare as a first significant step toward the national minimum income standard which we must, as a nation, ultimately guarantee.

- . The proposal for eliminating the widely varying definitions of eligibility for Aid to Dependent Children or Aid to Families with Dependent Children through a national definition of basic eligibility in a new family assistance program.
- . The feature of the program which offers incentives to welfare recipients to work and increase their incomes.
- . The creation of a computerized job bank and an automatic system for the expansion of training funds in time of need as useful steps to increase training and job opportunities for the disadvantaged.

The important objectives of the family assistance program will not be achieved, however, if state program variations are permitted to undermine the thrust of the proposed changes. Variations in work and training requirements as well as work incentives should be prohibited explicitly. Such variations would undermine many of the progressive innovations embodied in the legislation.

In addition, unless certain other proposals contained in the Bill are modified and still others extended, the Administration's essentially praiseworthy program may never get off the ground.

The Family Assistance System

State benefit supplementation requirements included in the "Family Assistance Act" should be made more explicit and expanded so that under no circumstance would states be permitted to reduce benefits or restrict Medicaid eligibility for all groups presently receiving public assistance or Medicaid. Moreover, additional Federal assistance should be made available to finance welfare benefits substantially beyond the proposed \$1600 Federally financed minimum.

The provision of the proposed Bill that requires the states to maintain at least 50% of their current welfare expenditures should be amended to require state supplementation of the Federal minimum benefit by an amount equal to at least 50% of the benefits now paid to eligible recipients. The Federal government should contribute 25% of the cost incurred by the state as a result of the amendment proposed above.

The family assistance concept contained in the Bill has a great deal of merit because it sets national standards and the principle of an income floor. By making mandatory on the states the requirement that families with unemployed parents be included in the welfare eligible groups, a constructive step forward in preserving family unity is achieved.

However, the Bill's provisions dealing with benefit standards and financing deal only with the most visible part of the welfare iceberg.

The proposed Federal standard is already equalled or exceeded in 40 states, and is more than \$400 below the national average welfare benefit paid to a family of four in 1968.^{1/} Clearly, the \$1600 Federal allowance, itself, cannot begin to meet the urgent financial needs of the families it is designed to assist. It must, therefore, be viewed as only a beginning step toward an adequate minimum income.

Even when supplemented by local efforts and food stamps, welfare benefits generally will fall far short of the \$3553 annual income, below which the Federal government currently classifies a family of four as impoverished.

The financing of the proposed program, in the words of Mayor John Lindsay of New York City, "fails completely to correct the present inequities in the distribution of Federal welfare assistance." Unless the financing is revised as proposed above, it appears that states which have done the most to help those in need will receive proportionately the least benefit from the family assistance program.

The level of benefits in the urban ghettos, which are fast becoming social tinderboxes, will be barely touched by the new program unless such additional financing is forthcoming.

Assistance at Full Need Standard

The UAW urges that the "Family Assistance Act" be modified to require states to provide benefits that meet their own current definitions of need. Such standards should be regularly revised to reflect rising costs and improved general standards of living.

The financing provision of the Bill does not even require or adequately encourage states to assure all public assistance beneficiaries of incomes which the states themselves define as adequate. According to the most recent report available, in 27 states, assistance payments have been at a level below the standards which the states themselves have determined as necessary to meet basic human needs.^{2/}

Unless the proposed legislation is amended, in many states, welfare recipients will continue to receive considerably less than what the state has determined as essential for minimum subsistence.

Food Stamps

The present food stamp program should be expanded significantly and placed in the Department of Health, Education and Welfare.

Food stamps are an important supplement to the meager income of the impoverished in our midst. Only when we have succeeded in assuring all Americans of an adequate standard of living should the food stamp program be permitted to terminate.

The provisions of Senate Bill 2547 that would continue food stamps on the basis that no family is required to spend more than 25% of its income on food is basically sound and would provide additional independence and dignity for those in need. The UAW also supports provisions of the Senate passed Bill that extend the use of stamps to cover personal cleanliness and home sanitation items, and which would provide free stamps for families with incomes below \$60 per month.

Recent Congressional proposals to reduce the scope of the Federal food stamp program and the program's retention in the Department of Agriculture are inconsistent with the basic purposes of the family assistance program.

General and Categorical Assistance

The UAW urges that the "Family Assistance Act" be amended so that general assistance recipients receive aid on the same basis as other welfare beneficiaries, at a level sufficient to maintain decency and dignity.

As a minimum, the proposed categorical assistance programs should be modified to at least provide benefits of \$100 per month plus additional allowances for any of the recipient's family members who could not reasonably be expected to work.

The welfare revisions included in the proposed legislation are inadequate because they completely ignore the unmet needs of many of those presently receiving general assistance, primarily single people and couples without children.

Present benefit levels for those receiving general assistance are plainly inadequate throughout most of the country. There is no reason to continue the neglect of the legitimate financial, training, and other

requirements of individuals and families without dependent children. Their right to a decent minimum standard of living is no less valid because of their family status.

The Administration proposal does include a \$90 per month minimum welfare benefit for those receiving aid to the blind, the disabled, and the elderly -- the so-called categorical benefits. While a Federal standard is definitely a step forward, the minimum established is inadequate.

Social Security and Poverty

As noted in the introduction, testimony before this Committee by the Alliance for Labor Action will include detailed proposals for an improved Social Security program. These proposals have the full endorsement of the UAW. They will include the establishment of a minimum benefit of \$100 per month and a 50% increase in all other benefits under Social Security.

These benefit increases, which have been recommended by the UAW for the past two years, would go a long way toward solving a significant portion of the poverty problem in the country.

It is not necessary to devise complicated welfare programs to eliminate poverty among the elderly. A sound and proved mechanism already exists in the Social Security system. There is no good reason why more than two million persons past 65 should continue to endure the demeaning stigma of Old Age Assistance.

President Nixon's proposal for a 10% increase in Social Security benefits is tokenism. It is less than the increase in Cost of Living since the last revision of Social Security in 1967; it fails to reestablish the purchasing power eroded by inflation. Furthermore, it does nothing to improve the inadequate benefits now paid and will further widen the income gap between the employed and the retired.

The Working Poor

The UAW is opposed to bringing several million of the working poor into the welfare system. The elimination of their poverty requires establishment of a minimum wage of at least \$2 per hour, supplemented by a realistic family allowance system and an improved Unemployment Compensation system with national standards.

The proposals to include the working poor under the "Family Assistance Act" deal with perhaps the most troublesome aspect of the Administration's welfare reform program.

In 1966 it was reported that one out of four poor families was headed by a man who had worked throughout the year. In fact, of the 3 million poor families headed by a man under age 65, half were "fully employed" in terms of time spent on the job. Though a number of these men had large families, many had low earnings that would be considered at the poverty level with only two or three children to support. All told, among poor families headed by men under age 65, five out of six of the heads worked sometime in 1966. The majority of those who did not work were disabled.

The UAW fully supports the objective of providing income incentives to encourage the seeking of employment for those who are able to work and to stimulate the marginally employed to become full-time members of the work force.

We believe, however, that the program outlined in the "Family Assistance Act" is not a sufficiently constructive solution to the very real problems of these twelve million people. The people involved are already working. In effect, the Administration program would provide new subsidies for sweatshop employers and remove incentives on employers to provide a living wage.

It would appear to be counter-productive to enlarge the nation's public welfare system when we are making efforts to change it.

Training and Work Requirements

The Bill should be amended to assure the availability of productive jobs after training. These jobs should be largely in the private sector, with backup public employment on useful community jobs and services. The Administration needs carefully to reexamine its policy of undertaking inflation control through measures which have already dangerously increased unemployment.

The objectives of the Administration program will only be accomplished in an economy geared to full employment at living wage levels. Those who are the first to feel the impact of unemployment are the most recently trained and most recently employed and largely those from minority groups in the urban ghettos.

Only through meaningful, well-paying work can a qualified individual take himself and his family out of poverty and off welfare. The creation of 150,000 new Federal job-training positions is a move in the right direction. Here, however, the promise of the proposed program may be greater than the reality.

Of approximately 10.2 million people receiving welfare benefits in the United States in May 1969, it has been estimated that fewer than 1% were able-bodied males. During that month, 28% of all welfare recipients were receiving benefits because of old age, blindness or other permanent and total disability. Nearly 48% of the recipients were children. An additional 16% had children in their care. The remaining group represented only 8% of those receiving welfare benefits, and included many who were disabled but couldn't qualify for full disability benefits, and many who were functionally illiterate or otherwise unemployable.^{3/}

To compel such persons to undergo training, or to hold out the hope of meaningful jobs would be cruel and self defeating to the vast majority of them.

Work Requirements for Mothers

The UAW urges that the family assistance plan be revised to remove the requirement that mothers of school-age children become ineligible for the program if they refuse to accept work or training.

The Bill should be further amended specifically to provide urgently needed funds and loan guarantees for the construction of new day care facilities.

We share the grave doubts which many have expressed regarding the social desirability and wisdom of any blanket measure which would compel mothers of school-age children to work or undergo training. To the maximum extent possible, growing children need the full-time love and care of their mothers, particularly when no father is present.

Mothers should have a choice between being full-time parents or working in order to supplement their incomes. Many mothers may choose to work. In fact, New York City has reported a backlog of mothers awaiting openings in training programs and in Day Care Centers. The financial independence and dignity possible through work provide a positive incentive. It is, therefore, neither necessary nor desirable to make such work mandatory.

This nation cannot afford a decade from now to face the magnified problems of delinquency and maladjustment in young people caused, in part at least, by forcing them to grow up in their most impressionable years without adequate parental supervision.

The UAW agrees with the principle of the Bill that many more training programs and Day Care Centers should be established. It must be recalled, however, that as of this date, the relatively modest Day Care provisions contained in the Social Security Amendments of 1967 have not been realized. Substantial funding as well as new and imaginative approaches are basic to overcoming the shortage of trained personnel and adequate child care facilities. Together with the provisions made for remodeling existing structures, such funds could provide new jobs for ghetto residents and add to Model Cities and other important programs for rehabilitating urban areas.

Although, as I have indicated, many of the underlying objectives of the proposed "Family Assistance Act", merit support, we urge that the changes recommended in this statement be incorporated into legislation to be adopted by Congress. The forward movement implicit in the proposed legislation should not be diverted.

MEDICARE - TITLE XVIII

The passage and implementation of Title XVIII of the Social Security Act (Medicare) rank near the top of social and political achievements of recent U. S. history. After more than a decade of study, discussion and debate, this nation established a publicly sponsored program of partial health insurance protection for a segment of the population whose great needs and slender means defied the best efforts of the private market to include them by voluntary methods.

Medicare gives tangible expression to this nation's determination to safeguard economic security and to assure access to the means of protecting and maintaining health for our older citizens, under a program that implicitly respects the concern for human dignity that is the hallmark of a free society. We in the UAW are proud to have been counted among the original supporters of the principle that adequate health care through Social Security is a right to be enjoyed by all our older citizens.

There is a growing awareness among the American people that health care is fundamental to the achievement of well-being and security for the family and the community. Now we have reached broad acceptance of the idea that access to modern health service is a right for all people, a right intimately related to the right to life itself. Medicare, in principle, recognizes this right for an important and growing segment of the population, and establishes public responsibility for a partial program of basic personal health care services.

Significant and valuable as it is, Medicare cannot be isolated from the massive health care crisis facing this nation. The American people are not receiving the kind of quality health services this nation is capable of providing for everyone. It is not just poor people, black people and -- despite Medicare -- old people who are receiving an inferior and costly brand of care, but also the majority of Americans in the middle income groups and those in whole communities lacking essential services. As a nation, we are continuing to commit ever increasing resources to an outmoded, wasteful and ineffective health care delivery system.

We in the UAW are convinced that conditions require total replacement of our existing health care "non-system" with a comprehensive universal program of national health insurance tied to our Social Security system. It should be our prime objective to restructure the way in which health care services are organized and

delivered and link that with effective means for assuring access of all persons to comprehensive prepaid health services of high quality. Ultimately, we believe that Medicare must be integrated into such a program. We are not content, however, to put aside the grave problems now besetting Medicare until the dawn of that bright new day.

Medicare is both a contributor to, and a victim of, the present American health care crisis. Bold, effective action now, pending full achievement of the kind of national system that must come, can provide some relief from that crisis.

It is in that spirit we say that Medicare is not as effective as it can be, that it has inexcusable gaps in benefits and coverage, that its premiums charges and coinsurance and deductible provisions are unduly and increasingly burdensome and that it is contributing importantly, and unnecessarily, to the general inflation of health care costs while reinforcing the defects of current methods of delivery.

After three years of operation, Medicare is paying about 45 percent of the cost of the total range of health care services provided to or purchased by Medicare beneficiaries. It does not provide coverage for the cost of prescription drugs used outside of the hospital, an item of expense that imposes a severe burden on many of the aged. Even with Medicare, it has been necessary to finance an additional 25 percent of the health costs of the aged through Medicaid. In fact, 45 percent of all Medicaid funds are being spent in behalf of persons 65 and over.

The remaining burden of health care costs, on the over age 65 group not met from public sources, still exceeds by a substantial margin that for the rest of the population. The annual per capita cost was \$176 for the aged, compared to \$153 for the non-aged in 1968. It also needs to be noted that only a small proportion of the privately financed personal health expenditures for the aged are covered by private insurance. In addition, Medicare's failure to cover all OASDHI cash insurance beneficiaries, particularly disabled workers who generally have reduced incomes and are often in poor health, and its inappropriate and punitive coinsurance and deductible features further dilute its value to beneficiaries and the community.

Medicare in its present form falls far short of providing the kind of financially adequate, comprehensive program which the aged require, and which must be provided if they are to gain full health security. We need to do better now. On behalf of the UAW, therefore, I want to express the hope that both this Committee and the Congress will give sympathetic attention to the recommendations which we offer.

MEDICARE AND CURRENT HEALTH SERVICES

The Crisis in Health Care

There is growing realization in America that the crisis in health care is becoming progressively more serious. The cost of health care is skyrocketing. It is the single most inflationary factor in the upward movement of the price index. While spending a larger percentage of gross national product for health care than any other country in the world, our nation's ranking in mortality and morbidity rates, compared to others, is a national disgrace. In no industrialized nation in the world is the gap between the "haves" and "have-nots", in their respective ability to gain access to adequate health care, as wide as in the U.S. Notwithstanding the massive effort of the insurance industry to redistribute the health costs of individuals through insurance, today only 1/3 of private consumer expenditures for health care are paid for by private insurance. Clearly, operating in the current medical marketplace, the private insurance industry cannot deal with the problems of achieving universal coverage nor provide an adequate mechanism for the control of both quality and cost.

Prices for health care services are skyrocketing as are aggregate costs of care for the aged. With respect to prices, the following data is relevant:

- (i) In the period from 1950 to 1969, total health expenditures rose by an annual average of 8 percent, but by an average of 12.2 percent in the past 3 years.
- (ii) The Consumer Price Index (all items) rose by 27.1 percent from January 1959 to July 1969; at the same time medical care prices increased by 52.2 percent. The rise in physicians' fees and hospital daily service charges from March 1959 (first date available) to July 1969 were 52.3 percent and 148 percent respectively.
- (iii) The average per diem cost of hospitalization was \$55.80 in 1968, up 59 percent from 1963, when it was \$35.11. If present trends continue, by 1975 a hospital bed will cost \$75 per day, a level already nearly reached in some parts of the country.
- (iv) By 1968, Americans were paying nearly twice as much (\$238 average) for health care as in 1960 (\$128 average).

This price inflation and the heightened effective demand for health services to the aged made possible by Medicare, have resulted in amazing increases in health care expenditures by, or on behalf of, the aged as shown below:

Estimated Per Capita Health Care Expenditure^{4/} for Selected Health Services for Persons Age 65 and Over, Fiscal Years 1966-68. ^{5/}

Type of Expenditure	<u>Total Per Capita Expenditure, Fiscal Year</u>				
	1966	1967	1967 As % Of 1966.	1968	1968 As % Of 1966.
Hospital Care	\$178.31	\$218.50	122.5	\$282.11	158.2
Physicians' Services	70.21	85.05	121.1	97.12	138.3
Nursing Home Care	68.92	80.30	116.5	91.28	132.4

The uncontrolled rise in the level of health care prices, as well as attributes implicit in our current systems for delivering health services, have had a special impact on the effectiveness of the Medicare program in meeting the needs of aged, on program costs, and on the volume and quality of services provided.

In the delivery of health services themselves our current system is characterized by an uncoordinated complex of institutional facilities and services often developed without reference to the volume and type of services needed in the community. These institutions are wasteful and inefficient in their internal operations, and reflect a period of historical growth unguided by concepts of planning and organizing of care at the community and regional levels. The medical profession has undertaken some commendable efforts to achieve better organization and more efficient use of personnel, but medicine remains largely an entrepreneurial system marked by unsatisfactory geographical dispersion of physicians, over-specialization, and an inability to provide uniformly high quality services to the total population. Equally relevant to Medicare, the profession prices its services without the restraints of the usual competitive forces of the marketplace.

The fragmentation of services and care inherent in these delivery systems is also, in part, a product of the institutional and professional control over the manner in which services are provided. The failure of these forces to guide and implement efforts to achieve high quality and standards limits Medicare's ability to establish necessary guidelines and controls, and to coordinate required services.

Thus, with one or two notable exceptions, Medicare has made no substantial efforts to experiment and develop innovative programs in purchasing comprehensive physicians' services from organized groups of physicians capable of delivering a full spectrum of physician services under group practice forms of organization. The division of hospital and medical services under separate parts in Medicare and the limitations, exclusions, and restrictions applied to the various areas of service covered, have been Medicare's responses to the "non-system" of health care in America today. In such a system, the Medicare patient must take his chances with the rest of the community.

We are fortunate in that, thanks to a combination of good sense, good luck and the devoted service of the Social Security Administration and the Bureau of Health Insurance, many of Medicare's provisions (some improvised to meet specific obstacles blocking the drive toward final passage of Medicare), have worked far better than could have been anticipated. We must also recognize, however, that flaws in the original conception of the program have produced results that are a continuing drain on the effectiveness of the program.

PROGRAM SCOPE NOT MEETING NEEDS

I. Coverage for costs of out-of-hospital prescription drugs should be immediately included as a new Medicare benefit.

Medicare's effort to recognize the complex range of services required to meet the health needs of the aged has a most serious deficiency in that it does not include the provision of prescribed drugs.

The members of this Committee must be fully aware of the extra heavy burden of prescription drug costs on retired persons compared to younger persons (more than twice the number of prescriptions and more than twice the cost per prescription as for the population as a whole) and the extremely heavy expenses incurred by the elderly with severe chronic conditions or with continuing requirements for maintenance drugs. Considering the health status and illness patterns of the aged, it is not surprising that as much as 50 percent of the drug costs of the aged are incurred by only 10% of the aged population, when these drugs are prepaid under comprehensive drug plans. I need not inform you that proposals for inclusion of coverage for prescription drugs under Medicare, have been endorsed by many thoughtful and responsible persons and groups, including the Task Force on Prescription Drugs, the Secretary's Review Committee of the Task Force on

Prescription Drugs, and by an advisory committee of which I was privileged to be a member, to the Senate Special Committee on Aging.

I can assure you, also, that the retired members of our Union are most deeply concerned over the burden of drug costs, an area of coverage not included, for retirees, in our negotiated health plans. Our retirees express their concern daily at our retired workers meetings and in letters, telephone calls and in conversations with UAW staff members assigned to our Retired Workers Department. It is evident from these contacts that the burden of drug expense often for lifesaving or life maintaining drugs, is overwhelming for many of these persons. We hear constantly of regular and continuing monthly expenditures for prescription drugs alone as high as \$35 to \$40 for individuals and more for couples. When regular month-in-month-out, expenditure for drugs takes 15 to 20 percent of a modest total income, that individual needs help. For others, with even more slender resources, the burden can be crushing.

What this means is vividly described in the following which are illustrative of the kinds of problems we hear about daily.

A retired American Motors worker living with his wife in a Detroit suburb have combined income from his limited Company pension and their Social Security of \$183 a month. From this limited income available to meet their entire living expenses, they are required to spend on a regular and continuing basis \$32 a month for prescribed drugs.

A 61 year old widow of a General Motors worker who died in 1963 does not receive the GM-UAW survivor pension she would have if her husband had died a year later, although the Union has negotiated Company-paid Blue Cross-Blue Shield coverage (excluding drugs) for her. She suffers from a heart condition and reports a monthly drug expenditure of \$37.00.

A 76 year old retired Chrysler worker wrote on October 22, 1969, in part, as follows:

"I am taking an average of 240 pills a month and sometimes more to live. I owe about \$80.00 now for medicine. I have spent or charged \$350.00 this year so far. My wife has to get me more medicine when she goes out tomorrow. I am 76 years old and we do not get enough pension to make it."

He goes on to say that his wife is "not too well herself" but failed to indicate her drug bill.

A General Motors retiree who wrote to express his disappointment at the fact that the Company does not pay for the prescription drug benefit that was negotiated for active workers, reports a regular \$30.00 monthly prescription drug expenditure for himself and his wife.

We believe that the exclusion of prescription drugs used outside of hospitals is one of the most serious defects of the current Medicare program. It would be tragic to continue to ignore this problem or to avoid facing it by calling for yet another study.

II. Medicare coverage should be extended to disabled beneficiaries receiving monthly cash insurance payments under the Social Security program.

Extending the protection of Medicare to disabled persons is also a question with which the members of this Committee are familiar. In 1967, President Johnson proposed it; Congress considered it and deferred action in favor of further study of the problem by an advisory council appointed for that purpose. Their report is now in. It confirms what has been evident all the time, namely; disabled persons need more health services and have lower incomes than the general population. They also have a correspondingly greater need for health insurance protection, but the conditions which create their greater need also make it difficult for them to obtain and keep adequate health insurance.

The council majority recommended hospital and medical insurance coverage under Medicare for all persons receiving monthly Social Security benefits on the basis of their disabilities. Such coverage would be financed by employer-employee payroll contributions and general revenues. Benefits would become available after a three month waiting period following the onset of disability. A more liberal definition of disability applied to workers age 55 and over, would permit them to become covered on the basis of less severe disabilities.

A minority of the council favored a more limited program with a longer waiting period for benefits, a more stringent test of disability and a separate trust fund financed exclusively by payroll taxes.

It is significant, however, that the views of all but one member share one common fundamental principle. But for the exception noted, all members looked to a social insurance solution to the problem through extending Medicare protection to disabled beneficiaries of OASDHI cash benefits.

The UAW supports fully the recommendations of the council majority.

III. Health insurance coverage should be provided under Medicare for non-aged and non-disabled beneficiaries of Social Security monthly cash insurance benefits.

We in the UAW believe that many of the reasons which suggest the desirability of including disabled Social Security beneficiaries under Medicare are equally persuasive with respect to other persons receiving Social Security cash benefits. Such persons include workers retired before age 65, dependents or survivors and the under age 65 spouses of retired or disabled workers.

While the UAW has had some success in negotiating health insurance coverage for survivors, it is common practice in many other employee group health insurance plans to discontinue coverage for all survivors upon the death of the worker.

Other persons may also lose their private coverage upon retirement, so that even if the retiree is eligible for Medicare, he may have dependents who are not. The entire family of a worker retiring at 62 may be excluded from all coverage both private and Medicare.

Many in these groups would be considered bad insurance risks in that they have high medical expenses. They also lack the means to pay for private insurance coverage.

INAPPROPRIATE CONTROLS AND LIMITATIONS

I. The present deductible and coinsurance requirements should be eliminated so as to provide for full inpatient hospital coverage, full hospital outpatient diagnostic services, no patient payments in extended care facilities under Part A and the entire reasonable cost of services made available under Part B, including services for out-of-hospital psychiatric care.

II. If the Committee believes the retention of patient payments is necessary, for reasons of "economy", the current levels of patient payments should be retained and general revenues made available to maintain the actuarial soundness of Medicare's Trust Funds.

Under a public program paying for services on behalf of a segment of the public, taxpayers have a right to regular assurances that the services are not being abused, that costs are maintained within reasonable bounds and that the services provided are not of inferior quality simply because they are paid for from public funds.

Although we have seldom heard of the Medicare coinsurance and deductible provisions as guarantors of quality, it is not uncommon to justify them on the grounds of preventing abuse and controlling costs. Endlessly, health insurance is compared to automobile and fire insurance. If the insured must share in the cost, the argument goes, he will see to it that only necessary service is performed, assume the minor losses and insist that charges be kept at reasonable levels.

Not only is the analogy inapt, but the recent experience with automobile insurance in this country casts grave doubt on the validity of the theory even as it is applied in that field. There is simply no evidence that indirect economic controls in the form of the Medicare coinsurance and deductibles have prevented abuses or had an effective impact in controlling costs. In fact, the only kinds of controls, on both quality and costs, that offer any prospect of success are those aimed directly at specific problems such as hospital overutilization, performance of unnecessary services and poor quality of service. When life and health are at stake, the proposition that we can minimize abuse and control costs by introducing obstacles to the receipt of service is not only doubtful but also inappropriate.

When the Social Security Amendments of 1965 became the law of the land, that law reflected an unequivocal choice between the two major conflicting alternatives available. We chose as the clearly preferred route, a program of publicly insured health care as a matter of earned right for all persons over 65 and rejected the means test as the sole determinant for assuming a public obligation to finance health care in that age group.

Having plainly chosen social insurance, we then, retreated from the goal by making the use of the program as painful as possible but still consistent with the need to provide a meaningful level of insurance. In part, the introduction of coinsurance and deductibles into Medicare reflected the reluctance of Congress to acknowledge the

deplorable inability of the aged to purchase health care and the vestigial survival of an exaggerated concept of "self-reliance". More importantly, the co-pay and deductible provisions were simply borrowed from so-called insurance principles underlying the commercial insurance industry's approach to sickness insurance.

In a period of just over three years, it has already been twice necessary to raise the level of hospital and nursing home patient charges under Medicare. The second such increase, which was announced September 27th to become effective next January 1st, will amount to more than 18 percent on the hospital deductible. It represents an increase of 30 percent over the original \$40 amount. It will mean:

- (i) an increase in the hospital deductible from \$44 to \$52;
- (ii) an increase in the patient charges for hospital confinement after the first 60 days and through the 90th day from \$11 to \$13 daily;
- (iii) an increase in the daily patient charges for 21st through the 100th day of confinement in a post-hospital extended care facility from \$5.50 to \$6.50, and
- (iv) an increase in patient charges from \$22 to \$26 for each day the patient draws on his "lifetime reserve".

We recognize that Medicare must be maintained on a fiscally sound basis. We believe this must not be done, however, at the expense of those who can least afford it, the elderly ill.

Medicaid is meeting a substantial proportion of the co-pay and deductible charges under Medicare. This transfer of revenues from one public program to another is technically unsound and illusory. Surely, for the sake of collecting some small part of the cost from those who cannot qualify for Medicaid, it was foolish to graft onto Medicare the confusing and complex apparatus of deductibles and coinsurance, and subject untold numbers of persons to means tests.

If we believe in social insurance, we should allow it to function. We need to be reducing and eliminating deductibles and

coinsurance, not increasing them. The imposition of "dollar barriers" represents a distinct hardship for those aged who have extensive and prolonged requirements for ambulatory care. They are particularly burdensome for aged persons who suffer periods of institutional care, and those whose resources are only marginally above the Medicaid qualification limits. What is worse, such charges tend to discourage early and continuous care and management of illness. They also require unquestionably uneconomic and incredibly complicated administrative arrangements and controls which cause great confusion and inconvenience to patients.

III. It is recommended that general hospital care be made available without durational limits, and that skilled nursing home care should provide up to 730 days for any spell of illness, with no prior hospitalization requirement. In addition, the unique limitations of the program related to mental illness should be discarded.

Closely related to our doubts about the usefulness and effectiveness of deductibles and coinsurance are equally serious doubts about arbitrary built-in time and dollar limitations on services provided.

We refer specifically to the maximum duration on covered hospital stays, the 100-day limit imposed on stays in extended care facilities, the requirement which prevents payment for extended care facility stays unless the patient is admitted from a hospital, and the special rules applicable to mental illness--both the more stringent limits on length of covered hospital stay and the \$250 annual maximum for out-of-hospital physicians' services.

The 1967 amendments to the Social Security Act recognized--admittedly with great caution--the inappropriateness of these limitations in a soundly conceived program of health benefits. This recognition consisted primarily of the addition of the so-called "lifetime reserve" of 60 days of partial coverage, elimination of the reduction in available hospital days for persons admitted to a general hospital from a tuberculosis hospital and the limited liberalization in the rules for reducing available days when a patient enters a general hospital from a psychiatric hospital. These changes can only be regarded as progress, however modest. Even these small improvements were seriously weakened by the decision to require patient payments equivalent to half the average hospital per diem cost for each day of use of the lifetime reserve.

A health program for the aged should be based on a full recognition of the known needs of some patients for extensive care and provide coverage appropriate to those needs. Artificial and arbitrary time limits, such as the 90-day maximum per spell of illness, supplemented by the lifetime reserve (with a 50% co-pay!) for inpatient hospital care, have no place in a public program. Relatively few need long-term hospital care but such cost can be prohibitive for the long-term ill. Here again Medicaid is inappropriately substituted for social insurance protection.

The restrictions on stays in extended care facilities can only reflect an unwillingness to face squarely the dimensions of the need among the aged for institutional care that is less intensive than hospital care. Perhaps, it is more expedient to "sweep it under the rug" by shifting a major share of the load to Medicaid and the states and then registering alarm at the soaring costs of Medicaid, than it is to deal with the problem.

As a member of the HEW Secretary's Task Force on Medicaid, I can tell you that the inadequacy of the Medicare extended care facility benefit is a significant factor in the total costs of Medicaid. It appears that as much as 35 percent of Medicaid payments are currently being spent on nursing home care, obviously on behalf of the aged, to cover nursing home costs of individuals who either were not admitted from hospitals or else have received nursing home benefits for a 100 day spell under Medicare and who, because of continuing illness or incapacity, do not qualify for another Medicare period of nursing home care.

Our UAW members, including retirees and their dependents over age 65 years, are insured for as much as 730 days care in approved nursing homes. On the basis of the first two years experience, maximum stays have not exceeded 150 days. Moreover, our program does not require discharge from the hospital as a pre-condition to admission to nursing home care.

Because of the type of patients involved, the limited experience to date with the use of nursing homes as an important adjunct to hospital care and problems inherent in the proprietary operations of these facilities, we believe there can be substantial liberalization while still recognizing the need to retain some limits on duration of stay in extended care facilities.

The discrimination implicit in the special time limitations and dollar restrictions applied to beneficiaries in need of psychiatric treatment is also unsound. The perpetuation of the distinction made between physical and mental illness is unscientific and no longer justifiable in a nation that is attempting in so many important ways to recognize the rights and meet the needs of the mentally ill.

MEDICAL BENEFITS: COVERAGE AND FINANCING

I. The UAW proposes repealing the separate enrollment and coverage provisions applicable to Part B and applying those of Part A to the medical benefits program so that everyone enrolled for hospital insurance would also qualify for medical benefits.

II. We also propose eliminating the monthly premium payments so that medical benefits will be financed in equal shares from general revenues and payroll contributions.

Inasmuch as the overwhelming majority of those eligible have elected coverage in Part B, it is apparent that they value its protection. Originally \$3, the monthly premium is now \$4. Additionally, the President, in his Social Security message to Congress, promised a "substantial" premium increase effective in July 1970. Now we are advised by the Commissioner of Social Security that the new premium will be more than \$5. The Administration says the increase is needed to keep pace with soaring medical costs.

We recognize the need to maintain the program on fiscally sound basis, but the method by which the beneficiary share of Part B costs are met, are already burdensome to the elderly and certain to become more so. Substituting an increase in payroll deductions for the current premium system--the remainder continuing to be paid for from general revenues is a more satisfactory alternative. It would simplify administration of the program, relieve beneficiaries of the burden of paying premiums at a time in life when they have limited resources and permit payment during the lifetimes of persons working. Our experience in UAW leads us to believe that many of the nearly one million persons insured under Part A who do not have Part B coverage have not enrolled because they cannot afford the premiums. It should be a matter of deep concern to the Congress that added numbers of the elderly may have to drop out when the premiums are raised to more than \$5 next July.

In addition, increases in costs could be taken into account in determining contribution rates and averaged over long periods of time. At the same time, anticipated increases in earnings over the years would generate added revenues from contributions to help defray increasing costs.

INFLATION AND COST CONTROLS

I. A price "freeze" should be immediately applied to each hospital and extended care facility until new, more satisfactory reimbursement formulas can be devised and implemented.

In view of the startling increases in the costs of hospitalization for the elderly, it is clearly apparent that basic modifications must be made in the current Medicare method of paying hospitals and extended care facilities. From the year 1965-66, prior to Medicare, through the program's second year, 1967-68, hospital care expenditures for the aged rose \$2.1 billion, of which \$1.3 billion represented the rise in hospital prices, and about \$700 million greater utilization of services. The remaining increase simply reflected the growth in the aged population.

The disturbing evidence of inflationary factors in charges for institutional services and the magnitude of projected expenditures here, clearly require administrative action, on an interim basis, to place some ceilings on reimbursements. The Department of HEW has conducted studies of the highly technical current cost apportionment formulas applied to hospitals (and the special apportionment problems of extended care facilities providing differential levels of care) and made proposals to achieve a more accurate apportionment of costs attributable to Medicare. Others have proposed reimbursement methods based on charges with reimbursements controlled by the level of charges of participating institutional facilities of similar size and function in the community. Whatever revised methods of reimbursement are developed, we urge that they include some definition of "allowable costs" based only on the cost of routine and ancillary services to patients, and without recognizing costs not directly attributable to patient care.

Our proposal for a "payment freeze" would simply limit future payments, perhaps for an interim period of three months, to the level of reimbursement paid to each institution, say as of November 1, 1969. This is, of course, a short-term and admittedly somewhat crude method of implementing an immediate brake on costs and is no substitute for new, rational and effective reimbursement systems.

II. Payment for physician services should be made only in cases where the physician accepts assignment. There should also be a more rigorous control over the method of establishing the level of "reasonable" charges.

It is particularly urgent to prevent further erosion of the value of Medicare arising from the inability of the program to control overcharges by physicians to patients.

From the inception of Medicare, there has been a continuing reluctance by physicians to accept the assignment method of payment. It is understood that at least one-third of the doctors are not accepting assignment. The current practice of paying physicians on the basis of itemized (unpaid) bills was a vast improvement for patients who now do not have to raise the funds and then wait for reimbursement. Medicare's inability to reduce overcharges to patients, is a tacit admission of inability or unwillingness to exercise effective public restraints on overcharging. A report by the staff of the Senate Special Committee on Aging found that we are, in fact, paying more for the services provided under the public program than what physicians are receiving from Blue Shield for comparable services paid for the working population under the most widely held private group contracts.

In commenting on the consequences of widespread unwillingness of physicians to accept assignment, an advisory committee to the Senate Special Committee on Aging said,

"Prior to Medicare, physicians often showed an understanding of their patients' economic circumstances and did not raise the fees they had been charging old patients for years on end. With Medicare, fees have been 'adjusted' upward so that is not too unusual to have the aged family spending as much out of pocket as before the program began, or even more, especially if the \$48 in Part B premiums is counted among their expenses, as it should be.

"The disadvantages of nonassignment are fivefold: (1) the aged person must pay the doctor's charges, whatever their level, without such deterrents as are imposed by having the fiscal intermediary screen for reasonableness and relationship to other doctors' charges; (2) the aged must themselves complete forms, submit claims, pay the bill, etc.; (3) the

higher charges soon become the accepted level of charges and are subsequently paid by the fiscal intermediary; (4) the dollar cost of the coinsurance of 20 percent mounts; and (5) workers pay more social security taxes as demands on the trust fund rise." 5/

With at least one-third of physicians rendering service under Medicare refusing to accept assignment, the program continues to provide easy opportunities to physicians for unjustifiable overcharges. Clearly the remedy is to limit payment for physician's services only to those cases where the physician accepts assignment. Such a change, however, might reduce the number of physicians prepared to provide service under Medicare. We would be prepared to take this risk on the grounds that the assignment method, in terms of the general public interest, is superior to any other system.

Hearings before the Senate Special Committee on Aging produced evidence of unjustifiable inflation of physician fees under Medicare's "reasonable" payment system. This system was, in fact, adopted from almost identical payment mechanisms used by private health insurance carriers. A substantial shift in methods of payment to physicians prior to Medicare by both Blue Shield and commercial insurance carriers, from either fixed fee "service" contracts or indemnity fee schedules to "reasonable and customary" or "prevailing" fees, was the prime factor in "locking in" the same method of payment for physicians under Medicare without some additional controls on remuneration of physicians by this method which are applied by private insurance carriers.

Expenditures by or on behalf of the aged increased by \$600 million, from the year prior to Medicare through fiscal 1968. Of this amount, price increases accounted for \$260 million. In view of this experience, it is necessary to test the validity of the "reasonable and customary" basis of remuneration in the absence of the control mechanisms common in private insurance. A thorough-going analysis should be undertaken of the available payment data with a view to determining how much the inflation of physician's fees under Medicare is related to the payment mechanism.

The recent increases we have seen in the costs of health services under Medicare are part of a widely perceived larger crisis in health care in America which is a major factor in the general rise of consumer prices. Reasonable people may differ over the extent to which Medicare is swept along in a general inflationary tide in health care and how

much Medicare itself is the "engine" of inflation. Nonetheless, it is particularly urgent to begin now to apply the recommendations the UAW is proposing to those payment policies and procedures which are permitting price inflation and further eroding the value of Medicare to the population it serves.

ADMINISTRATION AND RELATED MATTERS

I. The Secretary of HEW should be directed to develop a model system for administering Medicare at the state and local levels. Using the model system, State Departments of Health should gradually replace present administrative agents, with direct HEW operation where necessary.

Notwithstanding the safeguards on the use of private organizations in the administration of Medicare written into the law, we did not in 1965, and do not now believe it either appropriate or in the public interest to delegate, under any public program, the interpretation and application of public policy to private non-governmental agencies.

Moreover, the legislation established a potential conflict of interest within such private organizations, since most of the agencies involved act as agents of the Federal government and at the same time represent the providers of service under the program.

The experience we have had up to now strongly suggests that the use of private carriers has weakened drastically the ability of the Secretary of Health, Education and Welfare to control costs under both Medicare and Medicaid. This failure has added one more unnecessary "engine of inflation" to an already discouraging cost picture, without gaining any compensating increase in the quantity or quality of services.

The Advisory Committee to the Senate Special Committee on Aging reflected our concern over the now obvious failure of the system to establish effective cost controls over a reimbursement system which is itself controlled by the providers of service. The Committee said:

"The Advisory Committee has grave doubts as to whether, in the absence of a free market as is true in the health field, the concept of allowing the providers to control their own reimbursement is susceptible to the imposition of controls. The terms "prevailing" and "customary" are imprecise and hardly made less so by setting the computer to record the 82d percentile. Limits on frequency

"of allowing individual physicians to raise a fee merely shift to the patient the amount denied and postpone for a period the day when the higher fee is recognized as the particular doctor's customary one". ^{6/}

When the Secretary delegates administrative authority under the program to the agent of the hospitals (Blue Cross) or the agent of physicians (Blue Shield) there is substantial conflict of interest.

In the field of health services, payment policies and functions must be closely integrated with other vital administrative functions directed to the promulgation of high standards of care and services and to the application of safeguards against unnecessary utilization of services.

The 1965 legislation clearly recognized the advantages of combining the administration of financial and other management policies in a single agency. We are in full accord with this "single agency" concept. But such an agency, in our view, must not in any sense represent the providers of service and must be in some direct relationship to government and thus responsive to direct public control and public needs.

We must resolve the real or potential conflicts of interest inherent in the use of private insurance carriers and prepayment plans in the role of fiscal agents and fiscal intermediaries. These functions will never be performed in the public interest until they are performed by a public agency, preferably at the state level, if feasible.

While believing the current system to be most unsound, we recognize that many states do not at this time have a management system, computer capacity and other necessary administrative elements to quickly assume the administration of Medicare. But the operational capacity necessary can be developed, aided by standards and model systems and procedures developed by HEW.

In the event a State Health Department were not able or willing to be an administrative agent the Secretary should be required to arrange for direct Federal operation of the program in that state, through augmentation of existing HEW organization in the area.

A gradual substitution of direct State administration for the present administrators should prove of no real hardship to the latter. They obtain no real economic advantages under the current arrangements. Indeed, the present administering agencies would be able to

concentrate on their primary function -- underwriting and servicing their insurance business.

With the gradual extension into state administration, we are convinced Medicare would be more responsive to public needs and expectations, that the development of quality care, with sound utilization controls, would be enhanced and that realistic cost controls and payment policies would be implemented.

II. HEW should initiate projects using group practice plans and other organized programs and new reimbursement systems.

The failure of the Administration to aggressively promote under Medicare the use of direct service group practice plans and the emerging community service programs now being developed by medical schools and university health center complexes, is a matter of the deepest concern. Neither the federal department nor fiscal intermediaries have shown any real interest here, in large part because of underlying attitudes of "non-interference" with current modes of medical practice, which pervade the administration of Medicare.

In a time when both the President and the Secretary of Health, Education and Welfare are expressing deep concern over the crisis in health care, we must insist that new administrative interpretations under Medicare, or even more desirable, the Secretary's proposed draft bill "Health Care Cost Effectiveness" Amendments (to the Social Security Act) provide for specific direction to the Bureau of Health Insurance to initiate a series of new cost reimbursement programs for group practice plans, using per capita rather than fee-for-service payments for Medicare beneficiaries served by such plans. Vigorous promotion of such innovative programs would achieve for Medicare the demonstrable cost advantages inherent in these kinds of organized programs.

Equally important, successful programs with existing plans could form the basis of a wider application of new reimbursement methods using "per capita cost" concepts applied on an area-wide basis. The Social Security Act Amendments of 1967 authorized experimentation with various methods of reimbursement under Medicare and Medicaid to create incentives for efficiency and economy while supporting high quality services. Voluntary participation in such programs has not been successful and HEW has taken little leadership to initiate negotiations for experiments.

While recognizing that incentive reimbursement systems are difficult in an inflationary period, it is now critical that HEW move directly into some full-scale experimental projects using new reimbursement methods applied on an area-wide basis with the full cooperation of the providers of service and the professional associations.

UTILIZATION AND QUALITY CONTROLS

I. Full-scale Federal review programs, directed at uncovering the performance of unnecessary services and the provision of unjustifiable levels of care and establishing standards of quality and performance, should be initiated.

The disturbing evidences of fraud and near-fraud, the outright non-delivery of billed service and the current (and necessary) investigations surrounding such matters are tending to disguise a more fundamental deficiency in Medicare, its inability to date to establish adequate and acceptable standards for the level of quality and the volume and appropriateness of services performed. A strengthened and active National Medical Review Committee, aided by a much improved data reporting system for the fiscal agents and intermediaries, should be given responsibility for developing such programs, if the objectives of Medicare are not to be further eroded.

In the light of rapidly increasing costs, faulty controls and the appearance of numerous abuses, it is no exaggeration to suggest that public confidence in and support of Medicare is in grave jeopardy. Without timely and vigorous corrective measures, loss of support and confidence may well become irretrievable. Both President Nixon and Secretary Finch have demonstrated an awareness of the existing crisis and their efforts to deal with it are clearly well intended. But it is their perception of the magnitude of the crisis and the proposed remedies that are too limited in scope, and that will prove ineffective in application unless the program is modified in the manner discussed in this submission.

We in the UAW are convinced that the crisis in health care is so massive that it can be overcome only by replacing our present "non-system" of health care with a national, universal system of health insurance, comprehensive in benefits and coverage and built upon a foundation of a reorganized delivery system designed to provide high-quality care. We also believe that this view enjoys wide and growing support in the community at large and among leaders in business, labor, public life and the health professions, but we know too that Medicare's existing problems require specific, immediate attention because they cannot wait until we achieve a reorganized and revitalized health care system.

MEDICAID - TITLE XIX

In that portion of my statement dealing with Medicare, I expressed the belief that ultimately Medicare should be absorbed into a larger system of comprehensive, universal national health insurance. I also expressed the view that, in the absence of such a system, we should get on with the job of making Medicare more effective, extending benefits and coverage, and undertaking programs to assure the fullest value in terms of both quality and services, attainable for taxpayers' funds spent. I believe these views are compatible and consistent because the eligibility principles underlying Medicare (specifically eligibility based on social insurance criteria) are relevant to the development of universal national health insurance.

With regard to Title XIX of the Social Security Act (Medicaid), we are far less sanguine. In its present form, it is not a logical part of a national health insurance system; it is antithetical to one. It is a poorly functioning substitute that is compounding the massive health care crisis confronting this country. What it needs is not improvement, but replacement.

Whatever its faults, I believe it can be fairly said of Medicaid that conceptually it represents public acknowledgement of the inadequacies, indignities and poor quality of "welfare medicine" as we have known it in the United States. In good faith, Congress undertook to provide federal financial backing to assure the development of a single, consolidated, improved and liberalized program of medical assistance for everyone who might need it, regardless of age.

Good and honorable though the intentions may have been, if the "proof of the pudding is in the eating", Medicaid has a harsh and bitter flavor.

Although Medicaid was expected to reach 35 million persons by the time it was adopted by all states, it is serving less than one-third that number after three years and ten months of operation. Currently, there are 41 states, with approximately 5/6ths of the total population, operating Medicaid programs, but only slightly more than 11 million persons are covered by these programs. Moreover, these 11 million persons are not spread across the country uniformly, in proportion to the geographic distribution of the poor. (Information provided to the Secretary's Task Force on Medicaid was reported in the "Washington Report on Medicine and Health" for August 11, 1969, which states, "...two-thirds of Federal Medicaid money is going to six or seven states which contain only one-third

of the poor. ") If Medicaid were serving no more than 11 of the 35 million potential users, but doing that much, well and economically, one might conclude nevertheless that, the program is at least pointed in the right direction. Unfortunately, the opposite is true.

Medicaid has not yet appreciably affected the distinction in our country between those who can afford the services of medical care practitioners, and who receive reasonably competent and reasonably dignified, if not reasonably economic services, and those who can obtain no service when in need, as well as those who are often compelled to accept second-rate services. For what care is provided, the costs have been rising so alarmingly, that the members of this Committee scarcely require further documentation.

Knowing the large element of price inflation in Medicaid, the nation cannot accept with equanimity the program's disastrous cost experience, as reflected by the following:

- (i) costs rising from \$1.3 billion in 1965 to an estimated \$5.9 billion by 1970.
- (ii) cost increases of 57 percent between 1968 and the 1970 estimate, compared to an estimated increase in coverage of only 19 percent.

Another element of Medicaid's cost experience which deserves the Committee's serious attention, is the extent to which Medicaid is being called on to assist Medicare beneficiaries in meeting medical costs which are now uncovered by Medicare. It is alarming to note that of Medicaid's total payments in 1967-68, 39% was expended for inpatient hospital services and 31% for nursing home services. While data are not available to distribute these expenditures between those eligible or not eligible for Medicare, it is known that in the same year, persons 65 and older represented 41% of the total Medicaid coverage and 45% of Medicaid payments. It seems reasonable to conclude, then, that the very high proportion (70%) of Medicaid's total commitment which went for institutional services was on behalf of persons 65 and over. This illustrates not only the illogical dispersion of public funds through two different programs to cover the aged but also, of course, the built-in weaknesses in the current Medicare program.

Our current predicament is a product of a legislative program that prescribed inadequate guidelines for the states to follow in order to receive federal funds for the provision of medical care services to the indigent and the medically indigent who would qualify under a variety of means tests.

While the clear and laudable intent was to permit a wide and comprehensive scope of services, little attention was paid to questions of organization, efficiency, economy, or other issues involving control of quality or costs. It was legislation that UAW President Walter Reuther has correctly characterized elsewhere as "an almost complete capitulation to organized medicine in providing substantial public finances for use of this country's doctors, hospitals and other health resources, with very few requirements for meaningful accountability, efficient use or standards of quality."

I have no desire to fill the record with instances of abuses, skyrocketing costs, waste, inefficiency and the like regarding Medicaid. As a member of an advisory committee to the Senate Special Committee on Aging and a member of Secretary Finch's Task Force on Medicaid, I have come across any number of such reports. It is useless to repeat them; they are common knowledge. Hardly a week goes by without some startling new "revelation" which only further confirms what we already know of Medicaid problems.

It should be noted that the troubles of Medicaid have evoked some constructive countermeasures, but the overall response is one that could also have been predicted. On every occasion when concern is expressed over the rising costs of Medicaid, the panicky response has been to impose new restrictions on eligibility and to curtail further the already inadequate services provided. These restrictions include:

- (i) limitations on the number of services, visits or days covered;
- (ii) provisions which restrict recipients to acute and emergency care;
- (iii) requirements for the poor and marginally poor to share the inflated costs.

Rather than attempting to remedy the deficiencies of the program by establishing effective safeguards over costs and quality, the emphasis has been given to new severe restrictions and limitations which cruelly ignore the urgent health needs of those who require care, and the basic problems causing the gross increases in costs. It is not the people being served by the system, nor those whom the system fails to serve for lack of funds, who are at fault; it is the program itself which requires change.

On several occasions we in the UAW have not hesitated to acknowledge what we believe have been constructive efforts to gain some control over runaway costs and flagrant abuses. It is in that light that we regard actions such as the following:

- . the roll-back of the maximum level of reasonable charges allowed for physician reimbursement under Medicaid to the 75th percentile of physicians' customary charges in the community on January 1, 1969.
- . proposals for legislation to bar from participation providers of service who have been found guilty of fraud, over-utilization or otherwise abused the program.
- . a Senate-passed bill which would require a state desiring to cut back services to make certification of the effective controls it is exercising on the cost of its program.
- . a regulation effective July 1, 1970, requiring states to provide home health care for Medicaid patients who might otherwise require skilled nursing home care.

We cannot propose instant cures. Since, however, we recognize that Medicaid benefits are urgently needed by millions of our fellow Americans, we are proposing a number of recommendations as illustrative of what needs to be done to establish some degree of control and direction and to shape the program in the public interest.

RECOMMENDATIONS:

I. Mandatory State "Effectiveness Systems":

The Social Security Act should require mandatory implementation by all states of a uniform "Effectiveness System" based on a DHEW model, with implementation by a specified date, and federal sharing of the administrative costs involved, on a differential matching basis.

On the basis of information available, it appears there is no state which has established an effective system of reviewing and controlling utilization and costs or measuring the services provided from the standpoint of their appropriateness or quality. A much more comprehensive and forceful federal policy in this area is required than that

provided in the 1967 amendments to the Social Security Act (namely, Section 1902(a)(30)). Federal leadership can be enhanced by the development of "model" Effectiveness System and the provision of technical assistance to the states, in addition to sharing the administrative costs of such systems.

The effectiveness programs should be directed to accomplishing sound utilization and rational fiscal control mechanisms. Perhaps the most important utilization control function should be the measurement of the performance of providers of services whose service patterns deviate from ranges to be established.

It cannot be stated too strongly that the present chaotic cost and utilization review system is not functioning adequately. Major savings could be effected through developing a federal model program and making it available to the states.

But this alone will not suffice. When the review system raises questions about providers (charges, numbers of services, appropriateness of services, etc.), provision should be made for the state agency to make immediate referral to "peer review groups" (primarily professional organizations and utilization review committees). Such referrals should include time limits. If the peer review groups do not act within the time limits set, or if in the judgment of the professional staffs of the state agency the actions of the peer review groups are inappropriate or unsatisfactory, the state agency should, within stipulated time limits, plan to act on its own.

Once such a utilization review system is installed, if in the judgment of the HEW reviewing officials, it is not operating effectively, HEW should offer professional and technical services to the states involved to assist them in getting the system to function. Should these measures still not produce the required results, the Department of HEW should be given the authority to operate the utilization review system itself -- either from the regional offices or through agents in the states with whom contracts may be made.

In regard to fiscal control mechanisms, the most necessary seems to be a control system directed to the prompt identification of costs or charges which repeatedly exceed the acceptable range of cost or charges, with an appropriate mechanism established for revision of the acceptable ranges of costs or charges for all services, facilities and professionals participating in Medicaid.

II. Increased Federal Support for Better Organization and Delivery of Health Services:

Earmarked federal funds (perhaps 5% of Medicaid appropriations per year) should be available to the states on a non-matching basis to be expended in localities with a high proportion of low income persons or in localities with limited health resources which serve such persons in an attempt to improve the utilization, efficiency and/or quality of existing health services.

Such programs, under federal guidelines, should be developed towards more effective use of group practice facilities, home nursing programs, "meals on wheels" programs and other efforts directed to more efficient use of existing resources.

In addition to earmarking federal supplementary non-matching funds for such purposes, the Secretary of HEW should have discretionary authority to modify the federal payments to the states in order to encourage more economical delivery systems such as capitation payments to prepaid group practice plans, neighborhood health centers, or outpatient programs under the auspices of teaching hospitals, for the provision of comprehensive services to defined groups of Medicaid recipients.

Despite the demonstrated economy of providing comprehensive health services of good quality in prepaid group practice plans (e.g. Kaiser Permanente Health Plans in Los Angeles, San Diego, Northern California, Portland, Oregon and Cleveland, Ohio, Community Health Association of Detroit, Health Insurance Plan of New York), the wish of these plans to help make available better health care to groups of Medicaid recipients, and the possibilities of doing so under present legislation, only one modest program -- HIP in New York -- of such services is available to the poor. Efforts to provide such improved services in other areas, have been consistently blocked by rigidities of state and federal administrators.

Continued neglect of opportunities to provide better health services to the poor, within the framework of existing legislation should not be permitted to continue.

III. Federal Experiments for Incentive Reimbursements to Providers of Services:

HEW should actively develop experiments for incentive reimbursements of providers, both solo and group practitioners and for services rendered through reorganized outpatient departments.

In addition to the proposed amendments relating to this matter in the proposed Health Care Effectiveness Act, new payments systems should be developed and financed by the federal government on an experimental basis, for a limited time period of say 2-3 years, so as to devise payments which reward efficiency and discourage waste and inferior or marginal operations.

IV. Increased Federal Support for Construction and Renovation of Neighborhood Facilities to Provide Ambulatory Primary Medical Services.

The matching requirements under the Hill-Burton program should be modified so that higher federal matching could be available for this purpose.

V. Federal Assistance to Improve State Standard Setting, Certification and Consultative Services:

State standard setting, certification and consultative health functions should be administered in all states by the State Health Departments and these standards and functions should be identical for both Medicare and Medicaid where they are not now identical, namely, in respect to skilled nursing home standards in the Medicaid program. The Secretary of HEW should provide incentives, guidance and assistance to the states in this matter.

VI. Introducing Quality Standards in Medicaid:

While quality standards under Medicare are minimal, there is even less attention to such standards in the Medicaid program.

For example, the one locality known to the UAW, where the Medicaid agency attempted to introduce beginning quality standards, has now been forced to abandon them.

In order to assure a reasonable quality of service, the following limits for payments for services under Medicaid should be included:

- (i) hospitals should be required to meet the minimum standards of the Joint Commission on Accreditation of Hospitals and Nursing Homes;
- (ii) state limits on payment to nursing homes should permit a level of reimbursement which will assure reasonable quality of service, maintenance in accordance with carefully administered standards;
- (iii) except for emergencies and in isolated areas, only Board eligible or Board certified physicians would be paid for major surgery;
- (iv) only those doctors who can produce evidence of having kept up with professional and scientific developments in medicine would be recognized for payment;
- (v) physicians whose offices, upon inspection by public health officials, prove not to meet minimum standards would be disqualified.

VII. Improved Access to Coverage of Potential Recipients of Medicaid:

The states should be required to implement a simplified method of determining eligibility for Medicaid whether or not the individual has an immediate need for medical services. Such certification might be extended for a period of three months or even longer if a change in income is unlikely.

As an additional protection for both the recipient and the vendor, when services have been supplied but where no certification prior to the onset of medical need has been obtained, all states should be required to provide coverage for services for a period of at least 90 days prior to the time of application, provided the individual was eligible at the time the services were rendered.

VIII. Consumer Representation:

The requirement for consumer representation on state advisory bodies must be strengthened and enforced.

The federal government has the responsibility of guaranteeing that the consumer interest has effective representation. We believe there is inadequate consumer representation in most states of the nation. At a time when there is so much ferment among consumers over their wish and need to participate in Medicaid policy and program development, and when the policy of the Congress is to encourage such participation, on a constructive basis, it has not been possible even to secure minimal information on which to base a judgment as to whether the intent of the Congress is being carried out.

We will continue to believe that a universal, publicly supported national health insurance program offers the most satisfactory solution for meeting the personal health care needs of all Americans without regard to age, economic status, social class, sex or color. Until this nation is prepared to undertake such a program, all of us must recognize that the American people now regard access to decent health care services as a basic right for everyone. Insofar as it can be, Medicaid should be altered to assure that right, as effectively and as economically as possible, to those who are eligible.

SOURCES

- 1/ Based on average benefit paid under "Aid to Families with Dependent Children" and "General Assistance" programs. Derived from data included in Table M-23, Social Security Bulletin, September, 1969, p. 52.
- 2/ The number of states failing to pay benefits at their own assistance standards varies by program and family size. The above figure applies to a family of four receiving benefits under the AFDC program. OAA and AFDC: Cost Standards for Basic Needs and Percent of Such Standards Met for Specified Types of Cases, April 1968, NCSS Report D-2 (4/68), U. S. Department of Health, Education and Welfare, Social and Rehabilitation Service, National Center for Social Statistics.
- 3/ Percentages receiving welfare benefits are derived from data included in Table 3, Public Assistance Statistics, May, 1969, NCSS Report A-2 (5/69), U. S. Department of Health, Education and Welfare, Social and Rehabilitation Service, National Center for Social Statistics.
- 4/ Personal expenditures from all sources
- 5/ Dorothy P. Rice and Barbara S. Cooper, "Medical Care Outlays for Aged and Nonaged Persons, 1966-68", Social Security Bulletin, September, 1969.
- 6/ "Health Aspects of the Economics of Aging", prepared for the Special Committee on Aging, U. S. Senate, 91st Congress, 1st Session, Washington, July, 1969.

The CHAIRMAN. Thank you, Mr. Glasser, for coming back to the committee and giving us your analysis of these problems before us. You have been very helpful to the committee.

Are there any questions?

Mr. Corman?

Mr. CORMAN. Thank you, Mr. Chairman.

Mr. Glasser, would you have an ability to price out the cost of the welfare proposals if we assume that, first, all of the people who are eligible for public assistance began to draw it; and, secondly, all of the working poor who would be brought in under this program were brought in; and, further, we implement the requirement for child care centers and training for all of the women we are going to require under this provision to go to work? Would you be able to give us some figure as to how much we are really talking about if we do all of the things that we say we are going to do in the welfare part of this legislation?

Mr. GLASSER. I personally cannot do this off the top of my head. I know there are estimates in HEW and let me respond in a nonresponsive way. At least I know it is responsive, not fully, but only is partially responsive. I look at what has happened in the welfare field for the past 25 years during which I have been working intimately with it, and I look at the cost not only in dollars but the social cost to this country—and I say to you, sir, that when we see the figures which HEW can produce it would be a sound investment if we can restructure these programs to help people to become self-supporting. I think what has horrified me most about the welfare system with which I have worked is the development of what I call, and others have called, heredity poverty in this county. And if we can through these proposals begin to get out of the vicious cycle of the children of the children of the children being locked into poverty, I think it would be a sound social investment to follow the principles of the administration's program.

Mr. CORMAN. I wouldn't want to mislead you by my question in indicating that I do not support the goals set out in this legislation. My deep concern is this: I do not think that there is any figure before this committee as to what this is going to cost. I think the amount of money being asked for is totally inadequate and if we appropriate that little money the program is doomed to failure. I think that failure is going to be blamed on the poor.

Now, look at another entirely different program, in 1961 we said we were going to go on to the moon. If we had appropriated one-tenth of the money necessary, we wouldn't have done it. If we appropriate one-tenth of the money necessary to take care of the poor, we will not rehabilitate them. We will not give adequate living standards to those who cannot work. We always have the tendency to say, well, they were shiftless, they did not take advantage of this great effort on the part of the Government to get them off welfare and on payrolls; and I do think that we ought to look at how much we are going to have to spend to accomplish our goals. That is the reason I would hope HEW has these figures, and if not, that your research department independently could make some estimates.

I would call to your attention, for instance, that we anticipate it is going to cost \$1,600 minimum for a family of four. We also antic-

ipate it is going to cost \$1,600 to take care of one preschool child during the working hours in 1 year.

Now, it seems to me that neither figure is realistic. We ought to look at what it is going to cost but we ought not to underfinance it, doom it to failure at the start, and not give enough to the poor.

If your research department has any guidance for us, I would appreciate having it for the record.

Mr. GLASSER. I would be very happy to look into that very appropriate question. With the permission of the Chair, we would like to file a statement supplementary to these hearings because I think your question is very well put.

Mr. BURKE (presiding). Without objection, the record will be kept open at this point.

Mr. GLASSER. Thank you.

(The statement referred to was not received in time for printing.)

Mr. CORMAN. The Governor from New York indicated that we would probably need about \$5 million to construct child care centers. I expect that that would be a very sound investment for this Nation to make, but I would hope we wouldn't invest a tenth of that and then complain because mothers hadn't left their kids on the street and gone out to scrub floors some place.

Mr. GLASSER. Yes, sir.

Mr. CORMAN. Thank you.

Mr. BURKE. Mr. Conable?

Mr. CONABLE. Thank you, Mr. Chairman.

Mr. Glasser, I note your reluctance about endorsement of the provisions for the benefit of the working poor, and I understand them. I personally think this is the most important part of the provisions that have been made. I am a conservative, sir, and I believe in the system of Government we have and I think we have to make it work. I deal with lots of people who are concerned about our system and I find welfare one of the most visible parts of our social system and one of the most subject to criticism. The one letter I get from people that I just can't answer is the letter that says, "I work all year and get \$2,400 a year and the guy across the street from me is on welfare and gets \$3,000 a year. Why should I work?"

It seems to me that we have to take some steps in the way of providing some incentives for people to work, not from a punitive point of view, but from the point of view of recognizing that poverty applies to those who work as well as those who don't work. I am perfectly willing to acknowledge that it sounds like a rather expensive step that the President has proposed, but something of this sort, providing this type of incentive, I am convinced is necessary if we are going to have our system derive the political support it has to have if it is going to survive.

Now, I just hope we don't worry about cost to the point where we let the whole ball of wax go down the drain. I do think the American people want something done with their social structure so it will make more sense, and it certainly doesn't make more sense to give people incentives not to work.

Mr. GLASSER. Mr. Conable, may I respond to that?

Mr. CONABLE. Yes.

Mr. GLASSER. As I indicated, I share our troubled feeling. We are not the kind of organization that simply says we are for these programs and regardless of the consequences. I think our record has demonstrated that.

The objective of the proposal is one that we fully subscribe to. Our concern derives from the fact of the method proposed to deal with the problem. We think the method is inappropriate. We think the method should not be to bring people, more people, perhaps as many as 2 or 3 million, into the welfare system.

Mr. CONABLE. Eleven million.

Mr. GLASSER. I believe, sir, there are about 11 million eligible. Based on the experience of the past, one would guess that 2 to 3 million would apply and be declared eligible. They wouldn't all apply just as in fact today two out of every three who are eligible for public welfare do not apply. They are not on the rolls. So that is a guess. I don't really know what the number would be.

Our belief, however, is that we ought to provide rewards through decent wages that enable people to make a living without having to ask for government welfare to subsidize it. We are, therefore, proposing a \$2 minimum wage, which would take care of a good part of the problem and that this be supplemented by a family allowance system to take care of the large family. Our proposal would preserve the dignity and the independence of the worker that we both seek. This is really the difference.

The difference is in means; not end.

Mr. CONABLE. Well, I assume your organization has made some study of the extent to which increasing the minimum wage have an impact on unemployment. I know you are concerned about unemployment. We have had some fairly substantial increases in the minimum wage and I have to acknowledge that the misgivings you report about the possibility of government subsidy of sweatshop standards are real problems.

On the other hand, I don't think we want to price unskilled people right out of the labor market. We want to upgrade them to be sure, but I do think we have to consider this aspect, also. Really, what we are looking for is some degree of balance.

Mr. GLASSER. Sure.

Mr. CONABLE. And perhaps you and I would come out at a different place in considering what the proper balance should be.

The point I want to make, though, is that ultimately we have to face up to the problem of the person who can work only part time or can work only in comparatively low-skill jobs, because he simply cannot be upgraded into the higher wages levels for one reason or another. I do think that the President's proposal makes a rather courageous step in that direction.

Mr. GLASSER. The reason I press so hard on the minimum wage, sir, is that our union, as you well know, has testified for the various increases in minimum wage and I would say——

Mr. CONABLE. And I suspect your union would not be affected by the minimum wage at all.

Mr. GLASSER. We would not be. It is not a matter of our union's concern for our own members, you are quite right. The fears that have been expressed in the past about the adverse effects on employ-

ment of increases in minimum wages—and the last was a substantial increase—have in fact not been borne out. And we do not believe they would be born out in an economy which is continuing to expand as we have every expectation and belief that it will.

Mr. CONABLE. That is all, Mr. Chairman.

Mr. BURKE. Mr. Gibbons?

Mr. GIBBONS. Yes, I have a few questions.

I want to follow up on the question that Mr. Corman here started on and hope that you can really develop some definitive information for us.

I can remember when we declared war on poverty we first started out talking about a program that was going to cost \$5 billion a year. I think one time we almost appropriated \$2 billion a year and even \$5 billion, which as I recall, was only about five-twelfths of what was needed at the minimum estimate. I think one of the reasons the war on poverty has been such a miserable example of what shouldn't be done is the fact that by and large it never really got started. I hope that we don't launch off on another great crusade around here and find we are not coming anywhere near funding the problem.

If you can develop some outside information, relying upon your own expertise and your own independence, I think it would be a great help to the committee.

Mr. GLASSER. If I may respond, sir, we would be, of course, happy to do this and shall do it.

I would like to state further, however, that I am in complete accord with the views that have been expressed on this to the point of saying that if there are limited funds, let's do the priority programs and do them well. I would also like to make clear, however, there are some principles in the administration's proposals, such as the Federal standards and the Federal support, that to our view are absolutely imperative if we are going to get some different kind of mileage out of the welfare system. Thus it is a matter of both principle and money and we ought to spend those moneys to do the job well even if we have to do fewer programs and do them better.

Mr. GIBBONS. What I am trying to say, and we are probably pushing a lot of these things far beyond their capacity to perform, is I hope that when we enter into this brave new program here that we are headed in the right direction, that we can put some caliber on it as to the percent of need that it is really meeting. We should not go galloping off like we did here about 5 years ago with a billion and a half appropriation and thought it ought to cure all the poverty in the country in just 1 year or so but ended up with a very distasteful political situation.

Let me ask you about the experiment with the Kaiser people out there in California. Would you explain that to me a little better? What happened? What went on?

Mr. GLASSER. I am referring to the Kaiser Permanente Health Foundation which is a prepaid group practice plan which now operates in Portland, northern California, southern California, Hawaii, Cleveland, and Denver. There are similar programs not under Kaiser auspices, one which we in the UAW sponsor in Detroit, the Community Health Association. There is a similar one in New York City, the

Health Insurance Plan. There is one in Washington, D.C., the Group Health Association.

Mr. GIBBONS. When you said group or prepaid plan, how does it differ from the present type of plan that most of us see?

Mr. GLASSER. It operates, sir, in this way: For the payment of a monthly premium, which in the instance of our union members is the equivalent of the Blue Cross-Blue Shield premium, the member is assured complete health care in and out of the hospital, all laboratory, all X-ray, and all other major health-care expenditures, including mental health care and including prescription drugs. He pays nothing for any individual service. He is assured that if he needs a great many services or no services his premium is the same.

The objective of the plan is to keep him healthy. The objective of the plan is to keep him out of the hospital rather than to lie him down so he can get benefits under the insurance coverage.

Now, the Kaiser plans have almost 2 million members and the other plans have perhaps half as many as that in total, somewhat less than that. Under these program the entire family is covered and each member receives whatever health services he requires, including preventive health services, which are not usually included under other private insurance plans.

We have in these programs full-time physicians, nurses, psychologists, social workers, the whole health team who are employed on a full-time basis and paid in a variety of ways.

What happens is when a member needs care, he gets it at one spot. He has the whole range of health services available. He doesn't go into a hospital unless it is imperative that he do so.

In addition, these plans can realize the economies of large scale operation, and the advantages of having all the services together and of choosing a staff of health professionals by other professionals so that you have quality of care. We also have evidence that consistently over 7 years of study, for example, of Federal employees who have been in these plans—as well as of our own union members—that their rate of hospitalization is about half that of the matched groups outside.

Furthermore, the numbers of surgeries—this is always an indication of quality—hysterectomies, for example, various kinds of female surgeries, tonsillectomies, adenoids, and things of that sort, are very markedly lower because of the preventive aspect of group practice and because there is no economic incentive to get patients into the hospital to do a little surgery for a fee.

So these plans, I believe, have demonstrated that they can affect marked economies. And that is what we are seeing with the health care of the poor in Portland under this Kaiser plan which took several thousand poor into the plan and in the course of 12 months was able to drive down the cost of that care so that it is comparable to that of a matched group in the population outside the plan. Yet everything we know, shows that the health needs of the poor are very substantially larger than those of the rest of the population.

Mr. GIBBONS. In other words, they thought the poor people were going to cost them more because they came in in such bad condition, is that it?

Mr. GLASSER. That is correct, and because they live in poorer circumstances and things of that sort.

Mr. CORMAN. Would the gentleman yield?

Mr. GIBBONS. Go ahead.

Mr. CORMAN. I am not sure you brought it out, but it seems to me that the fundamental difference in the Kaiser plan from all others—(incidentally, one of the finest hospitals in Los Angeles is in my district, and is a Kaiser hospital)——

Mr. GLASSER. Then you know.

Mr. CORMAN. The services are all by contract. The doctors are on salary. They don't charge on a selling-their-services-to-the-individual-patient basis. Isn't that a significant part of the reason that the services cost less and that they get a greater quantity of delivery of health service for the small number of dollars?

Mr. GLASSER. That is part of the reason, of course. May I say, sir, that the Kaiser doctors, by and large, are in partnership. Only about a third of them are on salary. Two-thirds of them are partners in a program and share the proceeds.

Mr. CORMAN. Yes, sir, except insofar as the patient is concerned, it is not on a fee-for-service basis as all other health plans. All other health plans are on a fee-for-service basis in which the recipient pays about 20 percent. This winds up amounting to about what he thought his services ought to cost him, and Kaiser is a significantly different plan from any other.

Mr. GLASSER. That is correct. That is absolutely correct.

Mr. GIBBONS. You say there are only about 2 million people in the United States covered by these kinds of plans.

Mr. GLASSER. I think there are probably around 3 million. There are close to 2 million in the Kaiser plans alone and then there are a million in other plans, including the Group Health Association right here in Washington, D.C.

Mr. GIBBONS. Then about one and a half percent of the people covered by the plans and the other 97½ or 98½ are covered by other plans?

Mr. GLASSER. By the fee for service.

Mr. GIBBONS. Why is this so unpopular in the United States?

Mr. GLASSER. It isn't that it is unpopular. It is a different way of doing things. It is gradually taking hold. Basically, it requires physicians to be willing to associate in a new way and if I may say, it requires government officials who are spending government monies to be sufficiently responsive so that they can encourage the development of these new patterns. This is a newer pattern of delivering care.

Mr. GIBBONS. I don't think it is the newest. We have been getting it around Congress here for about 25 years. At least this is my estimation about how long it has been going on, looking at some of the pictures over there on the wall in the doctor's office. What kind of hard evidence do you have that day care is any better or any worse than a mother staying home with the kids? Do we have any real good evidence that day care is any better or any worse in the development of young people than the average mother in a poverty category? Do we have any studies or anything like that that shows what the effect is upon the child?

Mr. GLASSER. Regrettably, human beings and their personalities don't lend themselves readily to statistical studies. We have, however, very substantial experience over many years that shows, for example,

that a very large percentage of people who run afoul of the law can be demonstrated in their youth to have been kids from broken families, to have been kids who were neglected or dependent. A large percentage of them were known to public authorities as teenagers, as youngsters, who had been neglected or dependent and who were known to be troublemakers. Nothing happens to change their pattern because not enough is done about it.

We know that in those areas where we have latch-key kids, where we have kids who grow up under adverse circumstances without the guidance of parents, there is a much higher rate of delinquency, of neglect, and all the other things that go with it.

There is evidence of that all over the country and we are pleading with the Members of Congress not to create a situation which would expand that kind of thing because we don't want more and more delinquency control programs. We want family health programs.

MR. GIBBONS. There is really nothing to stop you having a latch-key kid even if you have a mother that doesn't work. I am not accusing any mother of being neglectful, but I know from having lived almost 50 years that some of them, even if they can stay home, are not really going to take much care of the kids.

Do we have any real hard information as to whether a child is really hurt by being put in a day care center and deprived of his mother's warmth and affection? Is there any factual information we have on it?

MR. GLASSER. We have only the testimony without variation of experts in this country over years who have dealt in this situation. Unfortunately, sir, it isn't possible to quantify it.

Are there neglected children in middle and upper income families? Of course.

Are there latch-key kids in middle and upper income families? Of course.

But the numbers are far greater among the poor families and in families where the parents are absent, particularly when these kids are left to run free in neighborhoods which are largely slums—you know the situation—which are crisis-ridden, which are ridden with prejudice and fear, et cetera. These kids pick up habits, in the absence of supervision, which I regret to say society pays for, as well as the individual subsequently, and I think one needs only walk through Harlem or 12th Street in Detroit or Watts, to see evidence of what you expose these kids to, in the absence of parental supervision.

MR. GIBBONS. But would you believe or would you think that it is possible for a society such as you have in Harlem, or Watts, or Tampa, Fla., to develop a real good program of day care that really gave good attention during, say, 8, 9, working hours a day to a child, enough food, recreation, education, to really enrich the child rather than perhaps leaving him at home with a mother who because maybe of her own past background or her own economic status can't develop the drive, the interest, doesn't have the experience patterns, and that women may be better off working and somebody else helping to raise her child that has had more experience.

MR. GLASSER. I would like to make my view clear, and my union's view clear on this. We believe that there ought to be funds for expanded day care programs. We believe in good day care programs. We believe they can do a great deal of good for many kids.

We believe that mothers of poor children ought to be treated like all other mothers in this society. They ought to be given a choice. That is the only thing we ask for, a choice as to whether they believe their children are more appropriately cared for at home or in the day care center.

If I may be personal, I have a working wife. I have had for a long time. I have a school age child. I have had several school age children. My wife has made a choice to work and we have made arrangements for our school age child. I think every mother ought to have a choice and poor mothers are not given a choice, but in the administration's proposals. We think this is what is invidious. We are not against day care centers; we are for them.

Mr. GIBBONS. I sometimes wonder about some of these statistics that we develop. It has been my observation as a lawyer that the kids of all generations, of all economic groups, get in trouble but the more affluent groups are usually able to put their child in a hospital or some other type of institution where the poor people just end up in jail, and I think our laws just sort of work that way, that if you are a poor kid and you get in trouble about the only place you can end up is the county home or detention farm or shelter place, whatever you call it. It is sort of a modified jail.

But if you are from a higher income category, you usually find a psychiatrist to refer your child to or some other sheltered care that is a little more dignified, and I don't think we are really getting a picture as to how serious this development of young people is, how badly distorted it is. I know it is bad in the low-economic areas, but I am afraid it is bad all the way up.

Thank you, Mr. Chairman.

Mr. GLASSER. I have no question that it is a serious problem in all levels of our society. I just say from our own experience in the union we would have to indicate that among the poor the incidence seems to be much greater, and I am not talking now about reported crime or anything of that. I know the problems with those statistics. The incidence is greater because, basically, sir, the problem in the ghettos of our cities as we have seen them, is that one has to fight to survive and the methods one has to use to survive are not those that society necessarily approves, and we are trying to suggest to you that in these welfare reforms the administration is proposing there is much there that will help to mitigate that. But we would hope that can be done without this requirement that mothers must go to work and kids must go to day care centers which don't exist in many places and in a way expose the kids increasingly to a fight for survival by methods that are adverse to our society.

Mr. GIBBONS. Thank you, Mr. Chairman.

Mr. BURKE. Mr. Vanik?

Mr. VANIK. Mr. Chairman, I have just one question which I would like to ask Mr. Glasser.

The President's proposal on social security calls for a deferral and a reduction in the rate of the tax projected out as far as 1987. Now, for the first 4 years of this program we are going to lose \$22¼ that would ordinarily flow into that social security fund. I don't know what the projection is if you put the 20-year test to it. Your testimony is silent on this. Do you approve or disapprove of the administration's pro-

posal to stretch out and reduce the social security taxes to this degree?

Mr. GLASSER. My testimony was silent, sir, because I indicated that, in order to conserve the committee's time, we said that the Alliance for Labor Action would be testifying on the OASDI cash benefits and we would associate ourselves with that. But since you asked, and I am glad you asked, our view is that we oppose this, that we in fact believe that this should not occur, that these revenues ought to be used to improve benefits, that the economy can take it, that the workers are prepared to take it, and that we would consider this an adverse measure.

Mr. VANIK. If we seek to do more with social security we certainly need this reservoir of resource rather than dissipating it.

Mr. GLASSER. We certainly do need it. We need a great deal of additional revenue and when the Alliance for Labor Action testifies, we shall spell out quite specifically how we see this coming.

I concur completely in your view.

Mr. VANIK. I thank the gentleman.

Mr. BURKE. Are there any further questions?

We wish to thank you, Mr. Glasser. You have done an excellent job, as usual, and we appreciate your testimony.

Mr. GLASSER. Thank you.

Mr. BURKE. Our next witness is William Robinson, chairman of the Committee on Social Affairs of the National Council of the Churches of Christ.

We welcome you to the committee. You may proceed.

**STATEMENT OF WILLIAM H. ROBINSON, CHAIRMAN, COMMITTEE
ON SOCIAL WELFARE, NATIONAL COUNCIL OF THE CHURCHES
OF CHRIST; ACCOMPANIED BY JOHN McDOWELL, EXECUTIVE
SECRETARY**

Mr. ROBINSON. I have with me Mr. John McDowell, who is executive secretary for the Committee on Social Welfare.

Mr. Chairman and members of the committee, my name is William H. Robinson, of Chicago, Illinois. I am a former administrator of the Cook County, Illinois Department of Public Aid, and am appearing before you today in my capacity of chairman of the Committee on Social Welfare of the National Council of the Churches of Christ in the U.S.A.

SUMMARY

The National Council of Churches supports the basic concepts of a Federal Family Assistance System as provided for in H.R. 14173. It holds that the proposed amount of basic grant is inadequate both to provide the necessities of life for poor families and to express our country's responsibility for its poorest residents.

The council favors improvements in job training and placement services and the application of fair labor and minimum wage standards to jobs considered "suitable employment" for adult family assistance recipients. It favors provision of jobs in public services under governmental auspices and with Federal participation in funding in order to make suitable employment available to all who are able and willing to work.

The council proposes the inclusion of childless couples and single individuals under 65 years of age in the family assistance program. We propose also that mothers of school age children where there is no father in the home be exempted from the work or training requirements of the act.

We urge the adoption of provisions which will make possible increasing the amount of basic family grants by administrative decision without further amendments to the act.

Mr. ROBINSON. We support the administration of money grants by the Federal Government. The administration of social services may well be delegated to State and local governments with Federal guidelines and Federal participation in funding.

The National Council of Churches is an organization of 35 Protestant, Anglican, and Orthodox communions having a total membership of approximately 42 million persons. One of the stated purposes of the council as set forth in its constitution is "to study and speak and act on conditions and issues in the Nation and the world which involve moral, ethical, and spiritual principles inherent in the Christian gospel." It is this purpose which leads the council to testify before you today on the issue of welfare reform in the United States.

Only the general board can speak for the National Council of Churches or authorize someone to speak for it. On September 12, 1969 the general board adopted a resolution which authorizes the testimony we are presenting today.

BASIS OF CHRISTIAN CONCERN

A long document could be written setting forth the "moral, ethical, and spiritual principles inherent in the Christian gospel." We will not burden you with such a document. As an indication of the council's proper concern with the subject matter of this act, I refer to the Gospel according to Matthew, Chapter 25, verses 31 through 46. Jesus, speaking to his disciples, set forth his ideas about the standards by which nations would be judged at the last judgment. He portrayed the Son of Man, the King, welcoming the blessed in these words:

"Come, O blessed of my Father, inherit the kingdom prepared for you from the foundation of the world; for I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me."—Matthew 25: 34-36.

In response to the question from the blessed asking when they had done these things, the King answered:

"Truly, I say to you, as you did it to one of the least of these my brethren, you did it to me."—Matthew 25: 40.

Jesus went on to give the other side of the judgment, the eternal curse visited on those who did not feed the hungry, give drink to the thirsty, clothes to the naked, and the rest.

In the face of this ultimate judgment, the National Council of Churches is impelled to present our testimony on such mundane matters as a Federal family assistance program and supporting programs to help relieve the burdens of poverty on millions of our fellow countrymen.

MANPOWER TRAINING AND EMPLOYMENT SERVICES

Since under this act it will be the responsibility of the Department of Labor to provide employment evaluation training and placement services to those referred by the Department of Health, Education, and Welfare, the success of this program will depend substantially on the effectiveness of these services. Past experience has produced too many examples of training people for jobs which do not exist. This is

frustrating to the persons being trained and wasteful of funds. The tooling up of the Labor Department's employment and manpower training services in order to make it possible for poor people able and willing to work to get jobs is the greatest urgency.

It is very important that fair labor and minimum wage standards established in law and administered by the Labor Department be among the criteria used by this Department to determine whether a job offered a family assistance recipient is "suitable" or not, as provided in section 102 of this act. Otherwise the Labor Department could be engaged in activities which defeat its own objectives. The act should specify standards to be met by employers whose bona fide job offers must be accepted by assistance recipients, unless they are in the exempt classifications.

PUBLIC SERVICE EMPLOYMENT

The Family Assistance Act must be supplemented by other legislation which will provide jobs in necessary public services where they do not now exist. Current employment in the private and public sector leaves about 4 percent of the work force unemployed. If the Family Assistance Act is to work as it is proposed there simply must be new jobs created. There is need for such work in services to older people and to children, in recreational and community rehabilitation services, but the provision of these services cannot, generally, be part of the profit-making private enterprise part of our system. Therefore they must be provided under governmental auspices. Their provision will not only make individual and community life in our country more humane, but will provide jobs to people who cannot find employment at present.

INCENTIVES TO EMPLOYMENT

The National Council of Churches welcomes the features of this act which provides financial incentives for the recipient to accept employment. These provisions represent a real turning point in aid to poor people when compared to present welfare programs. The act's provision for the "working poor" causes it to command our support, even though we are suggesting a number of changes in other provisions.

COVERAGE

The act represents so great an advance in the direction of providing financial aid on the basis of need alone, that we regret its failure to include single individuals and childless couples under 65 years of age among its potential recipients. It could go further in eliminating the chaotic and wasteful "categorical" system of public assistance than it does. The "general relief" category which receives no Federal support currently represents a financial burden on certain States and localities, results in complete neglect of certain needy people in others, and in general represents gross inequities. By broadening the coverage of the Family Assistance Act of 1969 to cover single individuals and childless couples under 65 years of age as well as families with dependent children, these inequities would be greatly reduced.

EXEMPTIONS FROM WORK OR TRAINING REQUIREMENTS

We believe that with a more adequate Federal base under income and financial incentives for employment and training as provided in this act, the great majority of poor people able to work will want to work. This even applies to mothers of preschool children provided adequate day-care services are available for their children, in and out of school. Therefore, we do not favor the requirement that all adult beneficiaries except those specifically exempted in the act as presented should be forced to accept work or training. We are strongly committed to the idea that people should be responsible to make decisions vitally affecting their lives. Especially do we believe that if employment or training is to be compulsory for any category of recipients, mothers of school-age children as well as mothers of children under 6 years should be exempt from this requirement. The school child rarely has school hours that are identical with mothers' work hours. Unless such mothers are exempt we would be adding substantially to the number of "door-key children" who let themselves into an empty home after school. In many communities shortage of classrooms has caused schools to operate on half-day sessions. Children of working mothers who attend these schools would be without adult supervision for a whole morning or afternoon, unless day-care services are provided. We applaud the commitment to provide child-care services for more children. We believe there will have to be appropriations for new facilities as well as for renovation of old, if the needs for day care are to be adequately met. We support very substantially expansion and improvement in quality of child-care services.

LEVEL OF GRANTS

The Department of Labor reports that \$5,500 per year is required to provide a minimum adequate standard of living for a family of four. The "poverty level" income for a family of four is variously estimated at figures between \$3,300 and \$3,800 per year. The National Council of Churches raises serious question about any guaranteed Federal floor to income which is less than half of the poverty level for a family where there is no one who can be employed. We recognize that the application of the work incentive provisions, which we favor, to a much higher basic grant would result in some families getting more than the "minimum adequate standard of living" as defined by the Labor Department. This does not disturb us. We cannot be comfortable as citizens of an affluent nation which refuses to consider lifting the level of some of our less fortunate fellow citizens above a "minimum adequate" level in order to assure many more people a chance to rise above sheer poverty.

We also recognize that in order to get a new principle of income maintenance incorporated in legislation it may be necessary to start at a less than adequate level of assistance. Such a compromise, undesirable as we believe it to be, could be accepted if the act provides for subsequent increases in the level of grants up to and beyond the upper level of poverty by administrative decisions which do not require amendments to existing legislation to promulgate.

SEPARATION OF MONEY PAYMENTS FROM SERVICE PROVISION

We strongly support the establishment of a Federal floor for family assistance which this act does. Past experience with welfare administration leads us to support strongly the idea of separating the provision of social services to those who want them from the issuance of money grants to those in financial need. In this way people who need money will not get services in place of money, but in addition. We favor the provision of social services by State and local governmental as well as voluntary agencies but believe that Federal participation in funding those services will be required.

In summary, the National Council of Churches supports the basic concepts of a Federal Family Assistance System as provided for in H.R. 14173. It holds that the proposed amount of basic grant is inadequate both to provide the necessities of life for poor families and to express our country's responsibility for its poorest residents.

The council favors improvements in job training and placement services and the application of fair labor and minimum wage standards to jobs considered suitable employment for adult family assistance recipients. It favors provision of jobs in public services under governmental auspices and with Federal participation in funding in order to make suitable employment available to all who are able and willing to work.

The council proposes the inclusion of childless couples and single individuals under 65 years of age in the family assistance program. We propose also that mothers of school-age children where there is no father in the home be exempted from the work or training requirements of the act.

We urge the adoption of provisions which will make possible increasing the amount of basic family grants by administrative decision without further amendments to the act.

We support the administration of money grants by the Federal Government. The administration of social services may well be delegated to State and local governments with Federal guidelines and Federal participation in funding.

Mr. BURKE. Thank you, Mr. Robinson.

Are there any questions?

We thank you for your testimony. You made a great contribution here today. Thank you.

Mr. ROBINSON. Thank you.

Mr. BURKE. Our next scheduled witness is Miss Dorothy I. Height. I understand that she is unable to be here. However, she will be represented by Mrs. Jewell Shepperd.

We welcome you to the committee, Mrs. Shepperd, and you may proceed.

STATEMENT OF MRS. JEWELL SHEPPERD, ON BEHALF OF MISS DOROTHY I. HEIGHT, NATIONAL PRESIDENT, NATIONAL COUNCIL OF NEGRO WOMEN

Mrs. SHEPPERD. Thank you. I would like to read Miss Height's testimony. I would like to say that while I am not prepared to answer any question on her testimony, I would be happy to convey any questions you might have to Miss Height, and with your permission she will answer those in writing. [Reads:]

Mr. Chairman and members of the Committee, as National President of National Council of Negro Women, established by Mary McLeod Bethune in 1935, I represent an umbrella organization of 25 national affiliate organizations with an aggregate membership of over 3,800,000 women based in local sections across the country.

As an organization founded by the daughter of slave parents, we have through the years worked to secure united planning and concerted action on the problems affecting the black woman and her family. Our goal has been to bring about the kinds of fundamental changes in society which will eliminate the "band aid" approach, the "first aid" treatment of our problems. We work so that black men can walk in freedom and equality without crutches.

We are strangers to neither poverty nor welfare. Statistical evidence shows that we are the poorest of the working poor and that as a group black people comprise a disproportionate number on the welfare rolls. We have, therefore, by virtue of firsthand experience, emerged as experts on poverty and welfare. We know that prejudice and racism in America has been largely responsible for fostering poverty and that, in turn, the fact of that poverty has been used as a justification for the perpetuation of the very racism which spawned it.

We welcome positive changes in the national attitude toward the rights of the poor and on that basis commend Mr. Nixon for his proposals for welfare reform, seeing them as the beginning of new and healthier attitudes toward poor people. Though we genuinely applaud any program which moves us in the direction of accepting national responsibility for the guarantee of livable annual income to American citizens, we nevertheless have grave misgivings about some of the proposed changes.

FEDERAL MINIMUM TOO LOW

The proposed Welfare Reform Bill sets the family assistance benefit at \$1,600 for a family of four, an amount that is \$2,100 below the national poverty level of \$3,700. Combined with the revised food stamp program, a family of four would receive benefits of only \$2,320, still \$1,380 below the poverty level. Since the Department of Agriculture claims that a family of four needs a minimum annual income of \$4,600, we would urge the following:

(1) That the Federal floor for family assistance benefits be no lower than \$3,000, thus allowing a family of four, including \$720 in food stamps benefits, an annual income above the poverty line.

(2) That in the case of earned income of a family, the state would disregard earned income at the rate of \$1,200 per year, reducing its supplementary payment between earnings of \$1,200 and a cutoff point for family assistance of \$4,600 for a family of four, the level suggested by the Department of Agriculture.

Given the provisions of the bill as it presently stands, the working poor would still be poor. If incentives are to be workable, then they must be real, not "paper" incentives.

LACK OF COVERAGE FOR SINGLE ADULTS AND CHILDLESS COUPLES

Unemployment, under-employment, poverty, and hunger do not distinguish married from unmarried, childless from child-bearing. Any bill aimed at welfare reform ought to include coverage of all who are

poor. Can we in all conscience set up qualifications for who shall eat and who shall starve? NCNW urges the amendment of the Family Assistance Act to provide for all people whose income certifications fall within the range of \$0-\$3,000. We urge an end to categorizing of the poor. To be in need is to deserve help.

EMPHASIS ON TRAINING RATHER THAN WORK REQUIREMENTS

The National Council of Negro Women feels that the proper focus of welfare reform legislation should be on training for the upgrading of employment of the poor, rather than on mandatory work requirements. It is our feeling that training makes possible upward job mobility and that herein lies the work incentive for welfare recipients.

We would urge the deletion of the mandatory work requirement entirely on the grounds that where training and employment are available at livable wages and where adequate day care is provided, the poor are willing, yes, anxious, to work. A guarantee of a job at a decent wage is a guarantee against any abuse of welfare benefits.

Further, we would caution against a work requirement which could be used to force welfare recipients into accepting undesirable jobs. It is for this reason that we urge that the supervision of work-training programs and work referrals fall within the purview of the Federal Government rather than the State Employment Services, as provided by the Family Assistance Act.

Variable standards from state to state could easily allow for situations where welfare recipients could be forced into labor settings which do not meet minimum Federal standards. The danger of the Federal Government's becoming a party to such exploitation cannot be risked. The right to family-assistance benefits ought not to be at the whim of a State Employment Services employee.

CONCLUSION

It is our belief that our recommendations will greatly strengthen an important piece of legislation which establishes a Federal floor on welfare benefits, ends welfare snooping, seeks to keep families together and provides work incentives for those in poverty. Our recommendations seek to achieve those goals described by the President: " * * * to raise the standard of living and the realizable hopes of millions of our fellow citizens. By providing an equal chance at the starting line, we can reinforce the traditional American spirit of self-reliance and self-respect."

Mr. BURKE. Thank you, Mrs. Shepperd.

Are there any questions?

The committee wishes to thank you for your appearance here today. You did a remarkably good job in substituting for Miss Height.

Mrs. SHEPPERD. Thank you.

Mr. BURKE. Our next witness is Prof. Milton Friedman.

We welcome you to the committee, Professor Friedman. You may proceed.

**STATEMENT OF DR. MILTON FRIEDMAN, PROFESSOR, DEPARTMENT
OF ECONOMICS, UNIVERSITY OF CHICAGO**

Dr. FRIEDMAN. Thank you, Mr. Chairman. I am glad to be here.

The CHAIRMAN. Mr. Burke, just a moment. I am a little bit out of place here.

Dr. Friedman, I want the committee to know that I have known you and know of you for many, many years, dating back to the time when I served with a great deal of pleasure on the Joint Economic Committee during the 1950's. I want to personally welcome you to the committee.

Dr. FRIEDMAN. Thank you very much, Mr. Mills. It is a pleasure to testify before this committee. My connections with it go back very much farther, to 1941, when I was an employee of the Division of Tax Research of the U.S. Treasury Department.

The CHAIRMAN. I know that.

Dr. FRIEDMAN. I strongly endorse the basic principles embodied in President Nixon's proposal for reforming our welfare system: the provision of a strong work incentive; the equal treatment of equals; eligibility requirements based on the objective criterion of income; the separation of financial assistance from other social services. These are principles that I have long supported and long urged. The President's proposal does not go as far as I would like to go in replacing the present welfare system by a system incorporating these principles, but it is a major and welcome step in that direction.

The proposed reform has the potential of greatly improving the social and economic conditions of lower income families in the United States, while at the same time reducing the burden imposed on the taxpayer to help the disadvantaged. But these high hopes will be realized only if Congress can avoid a number of pitfalls in translating the principles into practice.

In my testimony, I wish to direct the committee's attention to three problems that require careful treatment if the principles are to be made effective. Unless this is done, there is real danger that actions taken on the details of the plan will have the effect of completely undermining its effectiveness and of converting it from a major step forward to a major step backward. These problems are raised by a number of specific features of the imaginative and thoughtful proposal that is before you.

The problems are—and here I summarize the three problems and then I am going to return mostly to discuss the first of these. The problems are:

- (1) Keeping the marginal tax rate low enough to provide a real work incentive. This is by all odds the most important issue.

The basic marginal rate is stated to be 50 percent. However, social security and other taxes, and the method of handling State supplements and of integrating food stamps with welfare payments, threaten to raise the effective marginal rate to well above 50 percent, and in some cases to more than 100 percent.

- (2) Assuring equal treatment to equals. Persons in similar circumstances who are at the same income level should be treated the same whether or not they are currently receiving welfare payments. The present proposals do not achieve this objective.

(3) Providing administrative arrangements that will best lend themselves to further improvement and development of the welfare system. In my opinion, this would be achieved far better by having the Internal Revenue Bureau administer the negative income tax features of the plan along with the positive income tax than by assigning administration to HEW.

I. RETAINING A WORK INCENTIVE

In my opinion, the most important need in welfare reform is to provide a strong incentive for persons receiving governmental assistance to become self-supporting. The President's proposal does so by two key provisions: first, disregarding the first \$720 of earned income in computing benefits; second, disregarding half of the remaining earned income. As you are well aware, this is precisely equivalent to a tax schedule with marginal rates of zero at first and then of 50 percent.

For the class of persons involved, 50 percent is a very high rate. Yet, given the present low exemptions under the positive income tax, which requires that the payment of benefits be ended at a moderate income level, it is hard to construct a feasible scheme with a much lower rate. In my own proposals for a negative income tax, I have reluctantly recommended a 50-percent rate, viewing it as the highest that would give families a strong enough incentive to work themselves off relief.

The addition of an initial zero bracket seems to me an excellent idea. It provides maximum incentive where that incentive is most needed—to make the transition from no employment to some employment—and yet raises the breakeven point only modestly.

The two-step schedule of zero and then 50 percent is therefore an excellent compromise, and I support it fully. The problem is that, when additional features of the proposed plan, plus other features of current law, plus the proposals about food stamps, are taken into account, the final schedule is not a two-step schedule and the final rates are often far higher than zero and 50 percent.

This is clear from the figures in the accompanying table. I hope you gentlemen have this table, which is the last page of this prepared statement, because I would like to refer to it in explaining the further comments.

In constructing this table, I have described the proposal in tax terms, which seems the terms which would be most familiar to you gentlemen on this committee as well as the most effective way to present it.

(This description is different from the way I have usually described such plans. I have usually described them as involving an exemption and a schedule of rates for various brackets of negative taxable income (income minus exemptions). That description has the great advantage that it makes clear the relation between such plans and the positive income tax. For the present purpose, however, it has the disadvantage that both the exemptions and the rates are altered as additional items are taken into account. That is why I have used the equivalent alternative description embodied in the table.)

The way I have done it is to treat the benefit received by any family as the difference between two items: first, a basic benefit; second, a tax imposed on all income other than the benefit at graduated

rates but with no exemptions. The excess of the basic benefit over the tax is the net amount the family receives (or the excess of the tax over the basic benefit the net amount it pays).

To keep matters simple, I have considered only a family of four with two adults and two dependents, and I have assumed that any income other than the basic benefit is earned income.

The first part of the table, part A, is for the 20 States in which the family assistance program would replace completely the present AFDC program. In these States, the basic benefit—the amount that would be received by a family with no other income—consists of two parts: (1) A family assistance payment of \$1,600; (2) Food stamps worth \$720—or a total of \$2,320. This would also be the net benefit received if the family had no other income.

(In calculating the food stamp allowance, I have followed the President's proposal, which, as I understand it, would provide a maximum of \$1,200, this amount to be reduced by 30 percent of total income, including any family assistance benefit. A family that received the \$1,600 family assistance benefit only would therefore be entitled to \$1,200 less 30 percent of \$1,600 or \$1,200 less \$480, which equals \$720.)

If the family earns up to \$720 of income, its family assistance benefit is not affected, so the marginal tax rate, because of the family assistance plan, is zero. That is shown in the right-hand part of that first part of the table. The first column gives the income bracket, and the second the marginal rate for that bracket.

However, its food stamp allotment is reduced by 30 percent of its additional income, as I understand the proposal on food stamps that has been made, so the marginal tax rate because of food stamps is 30 percent. In addition, it will have to pay 4.8 percent for OASI and nothing for Federal income tax, so, going across the table, the total marginal tax rate on that first bracket is 34.8 percent, combining the food stamps plus the social security.

The next bracket runs to \$3,000, the point at which the Federal income tax, under current law, becomes effective. Your committee has, of course, voted to change this provision of current law, but in view of the uncertainty about the precise nature of the final tax reform legislation, I have thought it best to stick to the present law, including the expiration of the surtax.

In this bracket, that is, the bracket between \$720 and \$3,000, the family assistance benefit is reduced by 50 percent for each additional dollar earned, so the marginal tax rate because of the family assistance program is 50 percent. The food stamp rate drops to 15 percent from 30 percent because the food stamp allowance is reduced only on account of the extra 50 cents of each dollar of earnings that is retained by the family. The other items are the same as before, so the total marginal rate is 69.8 percent.

At \$3,000, the Federal income tax applies, making the total marginal rate 83.8 percent. At \$3,920, the family-assistance benefit has been reduced to zero, so this item drops out, reducing the total marginal rate to 48.8 percent. At \$4,000, the food-stamp allowance has been reduced to zero, so this item drops out, leaving only social security taxes plus Federal income tax, which combined equal just under 20 percent.

For the crucial range from \$720 to \$3,920, these are extremely high rates—as high as or higher than the top rate under our positive income tax. In addition, under present law, families on welfare may keep up to \$30 a week plus one-third of the balance of outside earnings without a reduction in benefits, so the effective rate for them for earned incomes between \$360 a year and \$3,000 is 66⅔ percent plus the social security rate, or a total of 71.5 percent, and for earned incomes above \$3,000, when they become subject to Federal income tax, 85.5 percent.

The marginal rates implicit in the family assistance program are only trivially lower than the rates in current law, except only for earned incomes between \$360 and \$720 a year. Yet we are all cruelly aware that current rates do not provide an adequate incentive for families to work their way off welfare.

Moreover, the rates in part A of the table are the most favorable. They are for the States in which the family assistance program will completely supersede AFDC. For all the other States, the marginal rates are still higher.

The exact rates vary from State to State, depending on the maximum benefit now payable. In section B of the table, I have calculated the rate for a sample State that has a current maximum benefit of \$3,400 a year for a family of four. I believe that this is roughly the maximum in New York and may be in others as well. In any event, it will serve to give approximate upper limits.

For such a State, the basic benefit has three parts, listed in the left-hand part of the table: (1) the family assistance basic benefit of \$1,600; (2) the additional State supplement of \$1,800; and (3) a food stamp allowance of \$180 (\$1,200 minus 30 percent of \$3,400)—or a total of \$3,580.

Under the proposal, the State is not permitted to reduce its supplementary payment on account of the first \$720 of earned income. It is permitted to reduce its supplementary payment by up to 16⅔ percent of the next \$3,200 of earned income and by up to 80 percent of still higher earned income.

I have assumed that the sample State applies these maximums. This explains the marginal rates in the column for the State supplement, which is the only additional column in the bottom half of the table compared to the top.

For this State, the food stamp allowance drops out at \$600, reducing the total marginal rate from 34.8 percent to 4.8 percent. The rate then jumps at \$720 to 71.5 percent, and at \$3,000 to 85.5 percent. These are precisely the same marginal rates as under present law. Above \$3,920, the rates are still more extreme, even exceeding 100 percent for a bracket just over \$500 wide, and then declining to 20.8 percent.

And even this is not the whole story. I have completely neglected city and States taxes on earnings or income, which, in those cities and States where they exist, raise the marginal rates still higher.

These are clearly not very desirable tax rate schedules. They are irregular, declining and rising in a pattern that it is hard to justify on rational grounds. More important, for most of the range of incomes they are far too high to achieve the objectives of the President's proposal. In no State do they provide much more incentive than does the present law for recipients of welfare to work their way out of welfare. In some states, they provide decidedly less incentive than the present law.

Persuaded as I am of the merits of the President's general approach, I am convinced that it would be a tragic mistake to enact it in the form embodied in these tables. These high marginal rates are, I am sure, inadvertent—the unexpected combined result or a series of separate decisions. In looking at them as a whole, this committee can enormously improve the present proposals by insisting that no combined marginal tax rate should exceed 50 percent.

The proposals that this committee has already made for reforming the positive income tax will help reduce the marginal rates. But this change, important as it is, will not bring them anywhere close to 50 percent for much of the income range.

The other measures that seem most promising are: (1) Reconsideration of the food stamp allowance proposal; (2) alternatively, revising the family assistance basic grant and tax schedule so that, when combined with food stamps, they provide the basic grant and tax schedule now proposed for the family assistance program alone; (3) not permitting States to reduce their supplement for the first \$3,920 of earned income, and then permitting them to reduce their supplement by not more than 50 percent of earned income in excess of \$3,920.

II. EQUAL TREATMENT OF EQUALS

Under the present proposal, if Jane and Mary work side-by-side in a factory, receive the same low wages, have the same size family, and are in similar circumstances in still other respects, they may still receive different net benefits. They will do so if Jane was formerly a member of a family on AFDC while Mary was employed and received no welfare payments, and if they are in a State that now provides benefits higher than the family assistance benefits. In that case, the State is required to continue to supplement the income of Jane but not of Mary.

Similarly, as I interpret the proposed law, Jane and Mary may have differential access to manpower and training programs and to child care services. If the earned income of both is high enough to reduce the family assistance net benefit to zero, but low enough to entitle Jane, who was formerly on AFDC (to supplementary State benefits, then Jane will also have access to the other programs, while Mary will not.

This is highly inequitable. It is also perverse in its effect on incentives. It encourages the working poor to quit working and to qualify for welfare in order to get the additional benefits. Equals should be treated equally.

III. ADMINISTRATION OF THE PROGRAM

I believe that our ultimate goal should be a complete integration of assistance to low-income families with collection of taxes from higher income families. All persons should be treated alike. All should be required to file the same or equivalent tax returns. If the income as calculated turns out to be below the exemptions provided by law, the taxpayer will be entitled to receive a payment, a negative income tax. If the income as calculated turns out to be above the exemptions, the taxpayer will pay a tax.

This will end the present demeaning division of our population into two classes—people on welfare and the rest of us. It will end the present demeaning eligibility requirements for assistance. It will sub-

ject all to the same criterion of ability to pay—a reasonably objective measure of level of income. It will also improve greatly the administration of both the positive and negative tax by requiring essentially universal filing and thereby reducing the opportunities for avoidance and evasion of tax. Finally, it will be politically healthy, because no additional benefits could be legislated without simultaneously altering the tax structure, and conversely.

This goal is thoroughly feasible in the not too distant future. The main obstacle at the moment is simply the different definitions of income employed for the positive income tax and the proposed negative income tax and the limited scope of the family assistance program.

The goal will become far less feasible, however, if the administration of the new program is assigned to the Department of Health, Education, and Welfare instead of to the Internal Revenue Service. That will assure the growth of two largely distinct administrative hierarchies, two sets of detailed regulations and rulings, and two sets of political vested interests.

In addition to keeping open the feasibility of an integrated income tax structure, there are other advantages in administration by the Internal Revenue Service, notably the contribution that would be made to the prompt and efficient collection of positive income taxes now avoided or evaded.

And I might add to my written testimony one minor example that I should have included. We now deduct tax at source through Internal Revenue withholding. The right way to provide an income supplement to people who are working but have incomes below the exemption level is to add to their paychecks in exactly the same process, which illustrates one way in which combining the two would render the administration of both efficient.

In deciding this issue of where the administration should be placed, I urge the committee to look not merely to the present but also to the future.

Thank you very much.

Mr. BURKE. Thank you, Professor Friedman.

Are there any questions?

Mr. BYRNES. Mr. Chairman?

The CHAIRMAN. Mr. Byrnes.

Mr. BYRNES. I was intrigued with your last statement about administration of income supplements. I think we do have serious problems. I have some great concern about using the Social Security Administration with the old age and survivors insurance system rather than having the administration of supplements stand separately. But I am intrigued with your statement that you would provide the benefits under the negative income tax through the paycheck.

Dr. FRIEDMAN. Yes. You see, that is the appropriate way to do it for those people who are receiving benefits, what the proposal calls the "working poor."

Mr. BYRNES. I wonder where do we come out when we start making the employer—

Dr. FRIEDMAN. We now do it. We now do it for the subtraction from the paycheck.

Mr. BYRNES. Well, we do in part, but then we also provide for a recapitulation at the end. You would be taking out money that the

employer has an obligation, in a sense, to pay to the employee in an employer-employee relationship. Now you would bring in an employer relationship to the Federal Government in terms of the money.

Dr. FRIEDMAN. Representative Byrnes, I would also in administering this program have an annual recapitulation for those who receive as well as those who pay. I would treat both groups alike. You must do that in any event because you will be operating the family assistance program on the basis of advance estimates and you need a reconciliation in order to compare what happens after the event with what was planned.

So the same worker, for example, might in some weeks be receiving a supplement to his pay and in other weeks having his income tax subtracted, because the same worker might one week have a wage that was so low that if he continued on that level for the year, he would be——

Mr. BYRNES. We have so much trouble today, though, Professor, in my judgment, with respect to the refund recapitulation with such a higher percentage having refunds. Would we get into a morass of problems here as we add this factor into the——

Dr. FRIEDMAN. This reduces that problem, Mr. Byrnes, because now one of the reasons you have refunds is precisely that if a person who is employed falls below the level at which taxes should be subtracted from his pay, nothing is subtracted and nothing is added. And as a result he accumulates a benefit which later on provides him with a refund.

By treating him throughout the year symmetrically on both sides of the exemption, the problem of refunds, I believe, would in the main be reduced and not made worse.

In both cases, it seems to me, the employer would be acting as an agent of the Federal Government. He is now acting as an agent of the Federal Government in subtracting the withholding taxes. He would also be acting as an agent of the Federal Government in supplementing the wages by whatever provision was made for such supplementation.

In both cases the employee would have to provide once a year a form reconciling what was deducted or added during the year with what he was entitled to and with his other sources of income. And it is precisely this possibility of combining these different parts or our structure that seems to me a major argument in favor of having this administered by the Internal Revenue Service rather than linking it with social security.

Mr. BYRNES. Of course, what we have done—and I think probably quite intentionally—is to have a system that in many cases overwithholds as a collection device.

Do you suggest that as far as the negative payments are concerned, you would underpay for the same basic reason, so that at the end of the year you would be more inclined to be paying the family some additional funds rather than having to require them to pay back some funds that they had already received?

Dr. FRIEDMAN. Under our present withholding we do have a great many refunds because of overcollection, but we also have a great many people who underpay and have to pay subsequently, because with the best will in the world it is impossible to collect from all accurately.

I would expect that doing the best job you could, you would find that in paying out the negative taxes just as in collecting the positive taxes, you would have a considerable number of people who would have to pay additional sums, but also a considerable number who would receive refund.

Clearly, if I were setting this up, I might try to veer us a little bit in the direction of underpayment but not much, because the contemporary cost to the people of being underpaid, it seems to me, would be rather important.

Mr. BYRNES. You address your whole paper here to the dollar-and-cents aspects.

Dr. FRIEDMAN. Right.

Mr. BYRNES. And, of course, that can't be underestimated in its importance, but to me one of the major thrusts of equal significance and importance, and which in some respects may be even more important in the long run, is the thrust of the administration proposal placing the emphasis on job training, bringing job opportunities together with the individual.

And I wonder whether the emphasis you put here doesn't almost ignore that aspect.

Dr. FRIEDMAN. I believe not.

Mr. BYRNES. Or do you think it can be ignored?

Dr. FRIEDMAN. Oh, no, I don't.

Mr. BYRNES. What is your attitude in that area?

Dr. FRIEDMAN. I don't believe it can be ignored. But I believe that those aspects of the proposal will not be effective unless the people involved have a very strong incentive to take advantage of the opportunities that are open.

Mr. BYRNES. That is your 50 percent?

Dr. FRIEDMAN. Right. It seems to me you have two problems. One is to have opportunities available. The second problem is to make the people themselves who are involved have a strong incentive to take advantage of those opportunities.

No civil servant bureaucrat is going to be able, with the best intentions in the world, to pick out which people should get the training, which people should have the opportunities, and force them to do it. That has to come from the individual himself.

One of the most effective ways to have it come from the individual is to give him as great an incentive as possible to take advantage of the opportunities available. We are, seems to me, asking a good deal of a very impoverished person, a person of a very low income level, if we say to him, "You go take a job and work, leave your home and incur the extra expenses of going back and forth. But, of course, you are only going to get back 30 cents for every extra dollar you earn, or at a higher level you are only going to get back 16 cents for every dollar you earn."

It seems to me that unless we can say to people, "You will get back half of what you earn, anyway, at least," it is going to be very hard to provide them with the kind of incentive that you and I would like them to have to take advantage of the opportunities available.

I may say on one other point that is suggested by your comment, one of the major reasons why I would like to see this handled evenhandedly, and particularly the withholding arrangement, is for nonmone-

tary reasons. If the program is handled by HEW as proposed, those people who receive a payment are in a wholly different category from those who don't. They have to go and make special application at a different office. They are going to get a separate check somewhere else.

Particularly for the working people who are receiving a supplement, if you can integrate the whole thing, everybody in that factory working in the plant is on the same basis. There aren't two classes of citizens. Everybody gets his paycheck at the end of the week. Some of the people who have had high pay have a little deducted. Others who have had low pay have a little added. And a person may shift from one category to another from month to month. From the point of view of morale and of not making people feel that they are somehow pariahs and making them participate in the activity of the economy, it seems to me that is a very great advantage.

Mr. BYRNES. Your paper and your comments are most intriguing and most interesting. Thank you very much.

Mr. BURKE. Are there any further questions?

Mr. Corman?

Mr. CORMAN. Thank you, Mr. Chairman.

Dr. Friedman, would you agree that we really can't consider a negative income tax until we get to the point where we tax all sources of wealth? We get ourselves in this dilemma where people may have a rather substantial number of dollars at their disposal and yet they aren't subject to the income tax.

What would we do with them when we talk about the negative income tax?

Dr. FRIEDMAN. This is what was intended in the comment I made here when I said that the chief barrier at the moment is simply the different definitions of income employed for the positive income tax and the negative income tax. As an ultimate ideal I agree thoroughly with what you say. I would myself like to see a far more far-reaching reform of the entire positive and negative income tax structure so that all incomes would be treated alike.

But I believe we want to be very careful not to let the best destroy the good. I think we are now faced with a situation in which we have a chance to improve the system as a whole substantially by introducing the principle of a negative income tax but with a different definition of "income" than that which is used for the positive income tax. That is a step forward.

Let's not refrain from taking it because there is a still bigger step that you and I would like to take as the opportunity offers.

Mr. CORMAN. Another question I have concerns the supplement to the paycheck. In the long run what effect is that going to have on the willingness of employers to pay living wages out of their own pockets.

Dr. FRIEDMAN. It will have no effect, sir, because the willingness of employers to pay what they have to pay does not derive from their social conscience. It does not derive from their concept of a living pay. It derives from competition. It derives from the fact that unless they pay as much as other employers pay, they are not going to get anybody to work for them.

So there is no reason that I can see why from the side of the employer he will be affected in any significant way by the fact that in part he is serving as an agent of the Federal Government.

Let me put it to you, if I may, another way. If his administering this for the Federal Government would affect him, then his knowledge that the individual is getting a supplementary check from the social security board or somebody else would have the same effect, and I think that it would be very hard on economic grounds to see any reason why that should have any measurable effect on the wages. Not that he wouldn't be willing to pay more. Any employer is willing to pay an indefinite amount if he can afford to do so. But he can't afford to pay more than the market requires him to pay to attract the labor, and he can't afford to pay less, because if he pays less, he doesn't get any workers. If he pays more, he is going to go out of business.

Mr. CORMAN. Yes, sir, but my concern is of the marginal worker, the person who doesn't have great skill, and there is competition for those jobs. It presents a dilemma. You don't want the man to live on less than a reasonable amount of money.

On the other hand, I would think that this employer might say, "I can pay you at the poverty level. The Government is going to subsidize a portion of it, and I will pay you the rest, and you take the job."

I think I would be concerned with whom we are really subsidizing with supplementary payments. It seems to me we have to hedge those with some protection for the other taxpayers, to require minimum wages or something of that sort. It seems to me we just compound the problem if we tell the employer, "You don't want to pay him any wages. We will supplement it, and you put it on the paycheck. And the employee is going to go home with enough dollars to keep body and soul together, even though it isn't going to cost you very much of it."

You really don't think that is a problem?

Dr. FRIEDMAN. On the contrary, I believe, sir, that it is really rather the other way around.

One of the reasons we have unduly high unemployment among the so-called "marginal" and "skilled" workers is because of the effect of the minimum wage rate, the legal minimum wage rate, which arises because of a confusion between a wage rate and income. It has always been a mystery to me how a teenage boy is better off being unemployed at \$1.60 an hour than being employed at \$1.40 an hour. And yet the effect of the minimum wage rate has been to render unemployed, people whose economic productivity does not equal the minimum wage rate.

What the well meaning proponents of the minimum wage rate have wanted to do is to provide some kind of a minimum income, not a minimum wage rate, which is of no value unless employment is available, on that rate. In fact, the effect of this kind of a negative income tax program is precisely that it serves the real function which the well meaning proponents of minimum wage rates have mistakenly believed that they could serve by minimum wage rates. It serves that real function of enabling people to earn what they can in the market, whatever their skill, and improve their skills through on-the-job training, while at the same time, through supplementing their income, you maintain a minimum level of take-home pay, which is available for them to purchase goods and services.

The fear that the employer would somehow be in a position to take advantage of this is a very understandable and natural fear. But I believe it does not correspond to the facts of the marketplace.

With respect to the group of workers we are now speaking of, there are, in general in most market areas in the country, a considerable number of potential employers. Those potential employers are in competition with one another, and they have no effective leeway to pay people less, simply because they are getting some supplement from somewhere else.

Mr. BURKE. Mr. Gibbons?

Mr. GIBBONS. Dr. Friedman, I am intrigued by your testimony. I never had an opportunity to read much of your material except what has appeared in the newspapers, and you have thrown some new light on it here today.

You are suggesting that perhaps a way that this could be worked, your negative income, is by adding through a private business employer an additional amount of money, just as we now deduct an additional amount of money from the paycheck for the Internal Revenue. I would assume, following that on through, that eventually the employer would have to get the money from somebody. He would get the money from the Government the same way he now pays the money to the Government. He would just submit a statement saying that, in effect, "I have so many people who are employed, and they have this kind of a social background. Therefore, I am entitled to money back."

This is a silly situation, but I could envision an employer perhaps going to employees and saying, "Maybe you better go home and have a few more kids. You don't want to work any harder, but I can get more money for what you are now doing."

Dr. FRIEDMAN. No, sir.

Mr. GIBBONS. You don't think it will work that way?

Dr. FRIEDMAN. No, it doesn't work that way now with the positive income tax. He doesn't say to the employees, "Why don't you go home so I don't have to pay over to the Government as much in withholding tax." The actual way it would work is that each employer would be withholding from most of his employees. The number of employees whose wages he would be supplementing would be relatively small. Given the kind of tax rates you have been thinking of, he would hand into the Internal Revenue a net payment. He would pay over. He would say, "This is the amount of money I have collected on your behalf. This is the amount of money I have paid out on your behalf. The difference is the amount I pay over to you."

Mr. GIBBONS. Wouldn't your program really encourage the employer to discriminate and to hire the poor and the disadvantaged and the large family person, as opposed to a single person, perhaps?

Dr. FRIEDMAN. Not at all. His wage cost is exactly the same regardless of the family status. His personal wage cost that enters into business calculations is not affected by the family status of the person, just as now the fact that he has to deduct more from the pay of a man with a small family, of a single person, than of a man with a large family does not lead him now to prefer the man with the large family. His wage cost is a wage rate he pays for the job to the man whom he employs.

Then in addition to that, he now serves as an agent of the Internal Revenue in withholding at source from that man's pay the taxes that are due to the Federal Government in the same way he would serve as an agent of the Federal Government or the Internal Revenue in paying over an additional sum to which the man was entitled.

Mr. GIBBONS. Let me give you an illustration.

Suppose you have a man working on an assembly line and maybe he is making \$2 an hour, and he is operating a machine or something like that. That would be pretty minimum pay. He turns out *x* number of products an hour, which result in an economic benefit to his employer, so much.

If that man were poor—of course, he would be poor at \$2 an hour—but if that man were poor, let's say, then his employer would, in effect, get a refund from the Federal Government, which he would in turn pay to that man.

Dr. FRIEDMAN. That is right.

Mr. GIBBONS. Yet he would still be paying \$2 an hour, wouldn't he?

Dr. FRIEDMAN. That is right.

Mr. GIBBONS. And maybe the man would then be taking home \$2.25 an hour, or \$2.50 an hour. It looks like to me that there would be a great encouragement in your system to hire the poor first.

Dr. FRIEDMAN. No.

Mr. GIBBONS. I wish you would draw me a picture of it. I don't want to take up the committee's time.

Dr. FRIEDMAN. Let me give you this.

Here right now an employer hires people at \$2 an hour, some of whom, for all he knows, have extra income and some of whom don't. Does that affect which ones he hires? Or does he pay those who have extra income outside less money than he pays those who don't?

Right now suppose you adopted the proposal as suggested by the President. Then the employer would know. He would know perfectly well that John Jones is getting an additional check from somebody because of the fact that he has six children and has a lower income than the income he would have to have in order not to receive a grant, so he knows what he is getting.

Employers are not fools. They know perfectly well what the other arrangements are, and so changing the bookkeeping by having somebody a block down the street hand the man the check, instead of combining it with the payroll operation of the firm itself, doesn't change the facts.

Mr. GIBBONS. I regret to say most of us live by forms. Have you ever gone so far in your thinking as to figure out what the new form 1040 would look like under your proposal?

Dr. FRIEDMAN. Yes.

Mr. GIBBONS. Do you have that?

Dr. FRIEDMAN. I don't have that with me, but I have in earlier cases when I have worked on this drawn up forms 1040 to handle the negative income tax.

Mr. GIBBONS. I wonder if you could just supply one, so we could put it in the record at this point.

Mr. Chairman, would that be all right?

Dr. FRIEDMAN. I will see if I can get one.

Unfortunately, I was unable to locate in time the forms I had drawn up earlier and time did not permit my writing out new ones in full. However, for form 1040, only changes that would be necessary would be (a) to add several lines in computation of tax parallel to those now used in computation of positive tax, e.g.:

"(1) If deductions and exemptions exceed reported taxable income, enter excess here.

"(2) See Tax Table— for payment to which you are entitled.

"(3) Enter advance payments received during year.

"(4) Enter any taxes withheld during year.

"(5) If (2) and (4) is greater than (3), enter excess here. This is amount you will receive.

"(6) If (3) is greater than (2) and (4), enter excess here. Remit this amount with tax return."

(b) To allow in b only of return for items of income on deductions treated differently for positive and negative income tax.

Mr. GIBBONS. At least mail me one, anyway.

Dr. FRIEDMAN. Sure.

Mr. GIBBONS. And I would like to see what the form looks like that the employer would furnish the Internal Revenue Service to claim the additional compensation.

Those are all the questions I have, Mr. Chairman.

Mr. BURKE. Thank you. We thank you very much, Professor Friedman, for your appearance here today and your testimony.

I can assure you the entire membership of the committee and the committee staff will study your statement very carefully and also your chart.

Thank you.

Dr. FRIEDMAN. Thank you.

(The chart referred to follows:)

MARGINAL TAX RATES IMPLICIT IN WELFARE PROPOSAL
[Family of 4 (2 adults, 2 dependents); all income earned (other than welfare grants and food stamps); city and State income taxes neglected]

A. 20 STATES WHICH NOW PAY BENEFITS LESS THAN PROPOSED FAMILY ASSISTANCE BENEFITS

Income bracket ¹	Tax schedule				Basic benefit		
	Marginal tax rate (percent)				Family assistance	Food stamps	Total
	Family assistance	Food stamps	Social security ²	Federal income tax ³	Total		
0 to \$720	0	30	4.8	0	34.8	\$1,600	\$2,320
\$720 to \$3,000	50	15	4.8	0	69.8		
\$3,000 to \$3,920	50	15	4.8	14	83.8		
\$3,920 to \$4,000		30	4.8	14	48.8		
\$4,000 to \$5,000			4.8	15	19.8		

B. SAMPLE STATE WITH CURRENT MAXIMUM BENEFIT OF \$3,400 A YEAR (NEW YORK STATE)

Income bracket ¹	Tax schedule				Basic benefit		
	Marginal tax rate (percent)				Family assistance	State supplement	Food stamps
	Family assistance	State supplement	Food stamps	Social security ²	Federal income tax ³	Total	Total
\$0 to \$600	0	0	30	4.8	0	34.8	\$3,580
\$600 to \$720	0	0		4.8	0	4.8	
\$720 to \$3,000	50	16.7		4.8	0	71.5	
\$3,000 to \$3,920	50	16.7		4.8	14	85.5	
\$3,920 to \$4,000		480.0		4.8	14	98.8	
\$4,000 to \$5,000		480.0		4.8	15	99.8	
\$5,000 to \$5,503		480.0		4.8	16	100.8	
\$5,503 to \$6,000				4.8	16	20.8	

¹ Income excludes basic grant and is all assumed to be earned income.

³ Present law, excluding surtax.

² Employee's tax under OASI.

⁴ Maximum permitted under proposal.

Mr. BURKE. Our next witness is Steven A. Minter.

Mr. VANIK. Mr. Chairman.

Mr. BURKE. Mr. Vanik.

Mr. VANIK. I would like to say before Mr. Minter testifies that we in Cuyahoga County pride ourselves on having one of the finest welfare departments in the United States.

We don't have the resources that we ought to have, but I know that Mr. Minter is going to present some very valuable testimony.

I want to point out to the committee that it was the Cuyahoga County Welfare Department that several years ago had one of the really successful community experimental programs in providing employment opportunities and converting a group of mothers from AFDC into self-sustaining people.

The success of this program, and the results of this work which was carried on in my county, had a great deal to do with the development of the family assistance program which was provided by the administration, and I want the committee to know that this was done under the auspices of the Cuyahoga County Welfare Department.

Mr. BURKE. You come very highly recommended, Mr. Minter. You may proceed.

STATEMENT OF STEVEN A. MINTER, DIRECTOR, CUYAHOGA (OHIO) COUNTY WELFARE DEPARTMENT

Mr. MINTER. Thank you, Congressman Vanik.

Mr. Chairman, members of the Ways and Means Committee, I appreciate the opportunity to appear and express my views on President Nixon's proposals for welfare reform, and the Social Security Amendments of 1969.

Welfare reform is a subject of great interest in the community that I come from. It should be, for there are 103,000 persons receiving public assistance in Cuyahoga County each month.

Public assistance recipients represent nearly 10 percent of Cleveland's population. Therefore, the future of the city will be greatly influenced by changes in the welfare system.

Cuyahoga County Commissioners Hugh A. Corrigan, Frank M. Gorman, and Frank R. Pokorny have exercised local leadership by supporting major changes in the administration of the Cuyahoga County Welfare Department, and securing a broader county tax base so that AFDC payments could be increased to a level of 24 percent higher than those in the rest of the State of Ohio.

The mayor of the city of Cleveland, Carl B. Stokes, established a Commission on the Crisis in Welfare in 1967, which made sweeping recommendations about changes that could be made to improve welfare services by voluntary agencies and local, State, and Federal Governments.

The Cuyahoga County commissioners and the mayor have worked cooperatively to impress the State legislature that appropriations for welfare programs must be increased so that payments would be consistent with the 1969 Consumer Price Index.

Other civic and planning bodies such as The Welfare Federation of Cleveland, under the leadership of W. T. McCullough, and the League of Women Voters have attempted to educate the community at large

about welfare problems, the need for increased appropriations, and improvements that could be made in Ohio's State plan for public assistance and medical care.

I appear today as an administrator of a State supervised but county administered welfare department. I will speak as a proponent for the welfare reform proposals, as I believe the suggested reforms point us in a direction that will ultimately have a significant impact on the cycle of poverty.

Yet, I have reservations about some of the legislative proposals that I would like to express. In addition, I would like to suggest some modifications that in my judgment would improve the administration of the public welfare system.

My comments are made from the perspective of one who is responsible for administering the regulations at the grassroots—where the recipients are.

ADULT ASSISTANCE PLAN

Perhaps the most far-reaching modification I would recommend in the proposed welfare reform bill is the transfer of all aged, blind, and disabled assistance to the Social Security Administration. This is not to say that the family assistance plan should not be established as a Federal program, but there are, I feel, several valid reasons why the adult programs should receive priority attention for this change.

From a management standpoint, I believe the Social Security Administration could gain valuable experience by first administering the adult programs. It has already been pointed out that this group is smaller and more stable. By working out the bugs in the system with this group, many problems I think could be avoided and anticipated before the transfer of the family assistance plan from the State to the Federal level.

The establishment of national eligibility requirements and the proposed Federal floor for benefits would make this an automatic process and reduce the tremendous administrative costs of these programs far below the present level. This measure will result in relieving the stigma attached to public assistance programs, particularly for those persons who because of age or physical disability have no means of improving their financial situation. The incorporation of these programs under the Social Security Administration would also bring us one step closer to the establishment of a single category of assistance based solely on the need of the individual.

The adult assistance plan is indeed a major step toward insuring a minimum Federal standard for those in our society who through the result of birth, age, or accident are unable to derive an adequate income from the economy. The Federal floor of \$90 per month, although meager, is the first conscious effort at a guaranteed annual income, and does represent for an aged couple an income slightly above the poverty line of \$2,100.

While it is generally recognized that rehabilitative services can, in some situations, result in self-support for certain individuals, in the first analysis those persons who qualify for assistance under this plan have little hope of becoming self-supportive. In a nation which through medical technology has extended the life expectancy of individuals far beyond that of a decade ago, it is essential that we provide an adequate means of existence for the aged. And there are few who

would argue that as a nation we can neglect to provide a source of income for those who are physically handicapped.

Perhaps one of the most encouraging pieces of this legislation is the recommendation that the Nation's elderly be incorporated into the comprehensive child-care program of the family assistance plan. A mutual assistance program of this type draws on the skills and talents of the elderly in working with children, and relieves in part the tremendous feeling of uselessness on the part of the Nation's aged. Those who volunteer to participate in this type of program benefit in two equally significant ways—psychologically and financially. The benefit to the children involved is perhaps immeasurable.

It is essential in discussing the provisions of the adult assistance plan to also examine the corollary provisions of the social security proposals. Here a major step has been taken in recommending that benefits be adjusted periodically to the cost of living index. It is also important to underline the provision of this bill which guarantees these adjustments to all beneficiaries of social security. The recommendation that these increases be made with no increase in the social security contribution rate is indeed a radical reform in former social security policy.

Increases in widow's benefits and uniform computation of benefits, regardless of sex, may result in a substantial reduction of persons receiving public assistance supplementation to social security benefits. A corollary provision providing benefits for persons disabled before the age of 22 may also reduce significantly the aid for disabled rolls.

FAMILY ASSISTANCE PLAN

The proposed family assistance plan represents a first step toward relieving many of the inequities of the present welfare system which have developed from the multitude of varying State plans. The draft bill defines the purpose of the family assistance plan as:

Providing a basic level of financial assistance throughout the Nation to needy families with children, in a manner which will strengthen family life, encourage work training and self-support, and enhance personal dignity.

Through this proposal, the President reaffirms the American concept of the family unit as the basic social framework of our society. He reaffirms the right of every American to privacy and dignity.

The program assures a national minimum income through Federal funding to all families unable to provide for themselves. It provides for State supplementation of this minimum level to insure that no family receives less than it would have under the AFDC program. The plan reasserts the administration's position on a simplified method of eligibility determination, and provides funding for child care programs. For the first time, the working poor will be eligible for Federal Government assistance.

The Federal minimum level of payment has been established at \$1,600 for a family of four, regardless of the cost of living index for a particular area. By the administration's own admission, this level is not "sufficient to sustain an adequate level of life for those who have no other income."

I strongly recommend that the Federal floor be established at a level which realistically reflects the cost of living index for urban and

rural centers alike. Unless the Federal floor is raised to a minimum of \$3,000 for a family of four, it is unlikely that families in northern urban centers will receive an increase in the already low payments. Furthermore, provision should be made in the family assistance plan to periodically raise the minimum level of payments so that it corresponds with rises in the cost of living.

The implementation of the family assistance plan at the Federal level will be an overwhelming managerial task, and I think I can speak from some experience. Unless the family assistance plan is divided into segments and phased in through a logical progression, there will be greater chaos than we have at the present time.

The primary step necessary for implementation of this program is the establishment of uniform national eligibility standards. For too long the potential recipient has been trapped by a combination of Federal- and State-defined eligibility requirements which have little or no relationship to the primary eligibility criteria—need. I strongly urge this body to prescribe national eligibility standards which cannot be adjusted by State administrators or legislators.

Millions of dollars are expended annually in the administration of requirements which have no relationship to the need of the individual or family for financial assistance. Many requirements have been universally applied on the State level which hold little meaning for the great majority of cases served.

The complexity of regulations has resulted in an administrative bureaucracy which forces the local agency to devote 75 percent of its staff time in complying with requirements, not providing needed services. For example, hours of staff time are expended exploring potential liquid assets of the applicant, including stocks, bonds, insurance policies, and bank accounts. Much effort is wasted in exploring the potential support available to the applicant through responsible relatives.

Families in need are forced to prove the absence from the home of the family head for at least a 3-month period, regardless of the reason for the absence, meaning that once they have established the 3 months, they are eligible for AFDC in the State of Ohio.

A maintenance system must not be encumbered by multiple requirements established at three relatively independent levels of government. If the proposed plan does not in fact eliminate many of the existing requirements, the Federal Government will just be taking over an administrative nightmare. All States should incorporate families headed by unemployed men into the State plan and standardize the eligibility requirements before transferring the AFDC program to the family assistance plan.

In order to insure the elimination of administrative red tape, the Federal Government should handle the payment of the State supplemental benefits on a reimbursable basis. There is no logical reason for permitting the States an option. Recipients should receive a single check.

I would also like to recommend that eligibility for the family assistance plan be determined every 6 months instead of quarterly. We know from experience that the task of redetermining eligibility every 6 months in the existing AFDC program, even with the use of simplified eligibility, requires extensive manpower.

The number of families whose income or status would change so dramatically in 6 months as to make them ineligible for a family assistance plan payment will not be great in a system which incorporates the working poor. Quarterly determination relieves anxiety about possible cheating, but may well cost far more than any potential savings.

The incorporation of the working poor in a Federal supplementation plan is a major and necessary step toward providing a financial assistance plan whose sole eligibility criteria is one of need. It is essential, however, that a program of this scope does not result in the subsidization of employers who pay substandard wages. It should not be the responsibility of the Federal Government to subsidize an underpaid, insecure labor force. Nor is it the responsibility of the Federal Government to keep a ready supply of low paid workers in the labor force.

Until a guaranteed minimum income is established which realistically reflects the cost of living index, the only solution to the plight of the working poor is the increase of the minimum wage for all jobs to insure an income at least at the poverty line level.

For the first time, our Nation will be stating that financial assistance is a right of every family whose income is insufficient to meet their daily needs. It will no longer be regarded by the recipients or the community as a privilege provided by the State.

REGISTRATION FOR WORK AND REFERRAL FOR TRAINING

The President's message on welfare reform proposes steps that will transfer welfare into "workfare." The cornerstone of the new system is the requirement that eligible adult family members would be required to register with public employment offices for manpower services and training or employment. The Bureau of Employment Security is then required to develop an employability plan for each registered individual.

This is basically a sound plan for all adult males who are not ill or incapacitated. They should be an active part of the labor force, and given priority for available training slots. In addition, the development of an employability and/or educational plan for 16-21 year olds who are out of school and unemployed must be accomplished. This age group should receive second highest priority for training slots and employment opportunities.

In addition, provision should be made to provide day care slots for the young unmarried mothers who are completing their education or participating in training. In many respects we may be able to accomplish more with the above two age groups. It could be argued that young adults should have first priority, since Federal benefits are not being extended to assist the single adult who is not handicapped or aged or the married couple without children.

I would underscore the remarks of speakers who have appeared before me who have stated that it is time that our Nation recognizes the need to provide assistance to persons in need, as well as families. It does not make any sense to deny childless couples in need financial assistance until they have their first child.

The major criticism I want to register about the proposed registration and referral requirements concerns the method by which

mothers of dependent children would be selected to participate in suitable manpower services, training, or employment. I believe mandatory registration and referral of mothers, with certain exceptions, is both unwieldy and unnecessary.

This approach requires the systematic screening and assessment of every case to determine the appropriateness of the referral. It eliminates to a great extent the self-determination of the mother who may have valid reasons for wanting to remain a full-time homemaker. In addition, it requires extensive processing and the development of employability plans, whether or not there are suitable jobs or training slots available.

The Cuyahoga County Welfare Department's experience over a 5-year period indicates that there has always been more women seeking training and/or employment than the community could provide. We administered one of the most successful title V work and training programs in the country. Every time we announced the establishment or publicized our special training programs, we were flooded with women applicants.

AFDC mothers were trained and employed as teacher assistants, dental assistants, social work aides, homemakers, home health aides, outreach workers, and clerk typists.

The Manpower Planning and Development Commission of the Cleveland Welfare Federation has conducted three studies of the federally funded manpower programs. The 1969 Manpower Planning and Development Commission Inventory on 14 Federal programs "estimates that the number of disadvantaged jobless at the close of fiscal year 1969 was between 22,000 and 24,000, which is only a small decrease over last year's estimate of 23,000 and 25,000." This estimate includes potentially employable AFDC mothers.

It should be noted, however, "that no study has been undertaken to determine the number of AFDC mothers who are actually employable * * *." Knowledgeable persons believe that the number of local AFDC mothers that are employable ranges from 5,000 to 7,000 of the 16,000 AFDC adult recipients.

My point is this—it does not make sense to screen mothers to determine employment potential unless there are sufficient jobs to warrant mass screening. Requirements such as mandatory assessment, referrals, and registration for large numbers of persons wastes scarce manpower and resources and adds to the frustration of recipients expecting to be placed in programs that will culminate in fulltime employment.

Instead of the present system, I would recommend that the Department of Labor and the local bureaus of employment security be required to establish special family assistant plan manpower units in each of the standard metropolitan statistical areas (SMSA) in the country. The bureau of employment security would be responsible for defining the local demand side of the employment picture for women—current and projected, including facts on such labor aspects as: number of jobs, kinds, qualifications required, wage scales, training requirements, et cetera.

I would want to pause here and note that to my knowledge no place in the country do we take this approach to try and do something about dealing with the problem of working mothers. I can find no place that lays out a plan that says, "We have even 500 jobs that need to be filled,

and these are the wages, these are the kind of qualifications," and so forth and so on, where that information is then sent to the welfare department and they say, "Now, recruit people for us to fill those specific jobs."

The emphasis has always been on this going through with IBM cards and all other kinds of things in selecting cases, and sending them all over, and the persons, when they get there, don't know why they are being sent.

The family assistance plan in cooperation with the welfare department would be responsible for recruiting and referring women to the bureau of employment security, and providing child care and other special supportive services.

This approach would eliminate depersonalized mass procedures, permit self-determination for all mothers, resolve the disputes about appropriate referrals. It would also dispel the myth about the thousands of jobs that are available for welfare mothers—"but they don't want to work because life on the dole is too easy."

CHILD-CARE SERVICES

The administration is to be commended for its proposal to establish comprehensive, high quality child-care services. At the same time, the standards for quality services should be written so that child-care programs can begin by meeting prescribed minimum requirements.

It is unrealistic to believe that a significant number of high quality child-care programs can be established in the immediate future. We recognize that new day-care programs cannot be custodial in nature. Yet, we cannot delay day-care expansion until each unit can furnish optimum services. Programs that provide the essential core services, and specify the steps by which additional supportive services will be obtained in the future, should be funded.

While it is essential to provide child-care services for preschool children, we should not lose sight of the fact that one-half to two-thirds of the children whose parents will be engaged in training or work are between the ages of 5 and 13. These school-age children must be provided quality care, also. In addition to supervision before school, often during lunch hours and after school, full-time supervision is sometimes needed on weekends, in the evenings, and during vacation and holiday breaks.

In order to develop adequate child-care facilities, provision must be made so that the cost of child-care services can include the construction of new facilities, as well as alteration, remodeling, and renovation. Certainly a requirement could be that construction not be permitted when there were suitable facilities available that could be remodeled.

Recipients under the family assistance plan should be trained to staff these centers as a step toward full employment in the job market. Family life education centers must be developed in areas easily accessible for the recipient. Resources must be provided to train mothers to better function in the home, and to better cope with the dual responsibilities of employment and homemaking. A comprehensive child-care program must include health and nutritional guidance programs. Emphasis must be placed on the interrelationship of family members, and their responsibilities to each other.

Complementary social services must be offered which serve both a preventive and rehabilitative function. Such a program, properly designed, can serve a day-care and educational function for both the parent and the child. If we are to break the "poverty cycle" in the future, we must begin today by instilling confidence and hope in the adults of tomorrow.

EMERGENCY ASSISTANCE

There is one other concern I want to register about the family assistance plan amendments. To date I have not seen any statement about meeting numerous emergency needs of poor families. At the present time, State and local welfare departments without receiving Federal assistance supplement adult and AFDC recipients who need carfare, taxicab vouchers, additional clothing, household supplies, emergency food and rent, household appliances such as stoves, refrigerators, washing machines, beds, et cetera. In many respects, this often can turn out to be a far greater crisis than the low welfare check they receive each month.

Individuals, or families, public assistance and nonpublic assistance recipients, occasionally require help in avoiding an eviction for non-payment of rent, or in paying a large utility bill acquired during the winter months.

Meeting basic needs such as these is more of an income maintenance problem than a social service one. In order for the family assistance plan to be effective, provision must be made to cope with emergent needs such as those described above. Federal funds should be made available so that assistance can be issued in instances of verified emergencies.

We support the administration's contention that there are many persons who are not public assistance recipients for whom social and rehabilitative services can be as helpful as they are for public assistance recipients. We look forward to the forthcoming legislative recommendations on social service.

In conclusion, I appreciate the opportunity you have given me to express my opinions about welfare reform.

I recognize that the Committee on Ways and Means faces a difficult task, for it has to make legislative recommendations that will have considerable impact on public welfare. There are no simple solutions.

H. L. Mencken once said, "There is always an easy solution to every problem—neat, plausible, and wrong." There is too much at stake in this country for the new plan to be wrong.

Thank you,

Mr. BURKE. Thank you.

Are there any questions?

Mr. Vanik.

Mr. VANIK. You have made an excellent statement to this committee, and I certainly concur in what you say.

Tell me, what is your total welfare budget in the area that you serve?

Mr. MINTER. This year we will spend approximately \$95 million.

Mr. VANIK. Of that money, how much is the Federal contribution?

Mr. MINTER. About \$42 million.

Mr. VANIK. \$42 million. And how do you generate the difference?

Mr. MINTER. The difference is county funds and State funds.

Mr. VANIK. How much?

Mr. MINTER. I would say this year it is going to be about \$10 million in county funds.

Mr. VANIK. \$10 million in county funds?

Mr. MINTER. Yes, sir.

Mr. VANIK. And the balance would be State?

Mr. MINTER. That is correct.

Mr. VANIK. Going back to your statement, the proposal which you made about incorporating the blind and disabled I think was also incorporated in testimony that our colleague, Phil Burton of California, had submitted, and I feel as you do, that this should be included in the program.

With respect to the need for reflecting in the allocation of funds to a community, the difference between urban and rural America and the differences in the cost of living indexes, to your knowledge, has the State of Ohio in any way concurred in that position, in the need for relating the program to the differential in the cost of living in urban areas as distinguished from rural areas?

Mr. MINTER. I am not aware of any statements made by the States in this area.

I think they have pretty clearly said that they think the Federal Government ought to take over the whole thing, but I have seen nothing that suggests that they think it ought to be also tied to the cost of living index.

Mr. VANIK. I like the section of your recommendations that you make on emergency assistance, because I think our costs are multiplying very often because of our failure to provide emergency assistance.

What, in your opinion, would be a good formula for establishing an emergency assistance program? Should it be a percentage of the total allocation, or how would you arrive at that?

Mr. MINTER. I think that would probably be the most realistic way to do it, would be to say some percentage of the total allocation to the amount spent in that community.

Mr. VANIK. What percentage?

Mr. MINTER. Well, let me just cite from our own experience.

We spend in local funds in the city of Cleveland each year approximately \$3 million, meeting just the kinds of things that I have outlined here.

Mr. VANIK. Emergency assistance?

Mr. MINTER. That is right, for primarily families who are receiving public assistance.

And I might say that is probably the foremost problem that communities are having to deal with today, and that the welfare departments are having to deal with.

If one would examine a great many of the concerns that welfare mothers indicate, the greatest is when these kinds of emergencies come up. It is when somebody's refrigerator burns out, and you have a low grant, and where do you get another refrigerator from to refrigerate your food?

We have never been able, very few communities have ever been able to meet those kinds of needs.

Mr. VANIK. That \$3 million, included in the \$10 million, is locally generated?

Mr. MINTER. No. I am talking about in addition to the \$10 million that is built into the Federal and regular GR assistance programs.

Mr. VANIK. So that actually if that \$3 million were released for matching, you could do a much better job on the other part of the program?

Mr. MINTER. That is correct.

At the present time, on that \$3 million, we get matching from the State in terms of general relief on a 75-25 basis, but there are no Federal funds put into this, and most of the supplementation goes to the Federal category.

Mr. VANIK. In our community, in order to save State costs under medicaid and cost of State mental hospitals, there is a program underway of moving the elderly and poor patient out of high level facilities in State hospitals into \$3 a day nursing homes.

Would you have any estimate of the number of people, and the cost of such actions to local welfare agencies, such as yours?

Mr. MINTER. Congressman Vanik, we at the present time are really not involved in that program, in that it is run strictly by the mental health, mental hygiene department of the State, so that very few of those persons happen to be welfare recipients at the present time.

To me the great tragedy is that what has happened there is that while everyone has deplored the circumstances, I have not heard anyone come out and say that really the basic problem is that for persons who are just returning from mental hospitals is that you have to provide a care for them which is obviously much more expensive than \$3.30 a day.

We have deplored the conditions, and talked about the poor housing, and all of those kinds of things, but refuse to look at the basic cause, which is that that will not pay enough money to assure some kind of decent standards.

Mr. VANIK. How many of these people are there now, that you know of, in our community?

Mr. MINTER. Well, it has been estimated that somewhere over a thousand persons have been released.

Mr. VANIK. Moved and released from hospitals?

Mr. MINTER. Yes.

Mr. VANIK. And thrust on the community with no provisions for their support other than the \$3 a day?

Mr. MINTER. That is correct.

Mr. VANIK. Last year I sponsored legislation to extend school lunch type assistance to day care centers such as Headstart, and I understand that this program is not being utilized in Ohio to the extent that I hoped it would. Can you tell me anything about that?

Mr. MINTER. I am not familiar with all of the particulars of the legislation that you sponsored.

Mr. VANIK. There is a requirement that funds go to nonprofit institutions providing food. While some of the people that you place out would be in such institutions, is that not one of the bars to utilization of this legislation, or are you not familiar with that?

Mr. MINTER. I am not familiar with that piece.

Let me say, though, that I am somewhat optimistic that we will see some major changes in the administration of day care in the State of Ohio. This session of the general assembly did pass a rather compre-

hensive day care standard licensing bill, and also an appropriations bill to try and attract Federal funds, and I am aware that we do get food subsidy funds through the Department of Agriculture for some particular centers which we are cosponsoring in Cleveland.

I think there are some forward steps being taken.

Mr. VANIK. Have you been able to utilize Public Law 90-302?

Mr. MINTER. Not to any great extent, no.

Mr. VANIK. I will not take any more time.

What is the total number of cases that we have in your jurisdiction?

Mr. MINTER. We have some 38,000 cases.

Mr. VANIK. 38,000 cases, and the breakdown of those is?

Mr. MINTER. It would run approximately 16,000 AFDC regular, about 500 aid to dependent children of unemployed parents, around 9,000 aid for the aged, about 7,000 general relief recipients who are not Federal responsibility, about 300 blind, and about 6,000 AFD.

Mr. VANIK. Could you describe general relief in Ohio and some of the problems connected with it?

Mr. MINTER. In every State we have general assistance programs where the States set their own standards to provide assistance to certain categories of persons who are not eligible for Federal assistance.

And one of the things I would like to see incorporated, if we can ever get to a single kind of system, is the elimination of general relief.

Let me cite an illustration of the crazy kind of bureaucratic situation we have now. We could have a man come in and apply for assistance who is unemployed but handicapped. Maybe he has a serious drinking problem. Maybe he is just 55 years of age and cannot get work.

At the present time, there is no Federal program that he would be eligible for, so we put this man on general relief, having made the determination that in fact he is not employable in today's labor market.

If he seems physically handicapped enough, we will send and get the physical examination and write a social summary and send it to Columbus to see whether this person could qualify under the aid for disabled category as established by the State and Federal Government.

Perhaps he qualifies for that. Then, if he qualifies for that, we start exploring; well, maybe he is eligible for social security disability benefits under the OASDI program, and you can see the tremendous amount of paperwork and shuffling and moving this person around, and the great difference in terms of the benefits between the programs in the payment for medical care, when we have already started with the very basic fact that the man is unemployed, unemployable in the labor market, obviously is handicapped, and no one at all is debating that he is going to have to be dependent upon some kind of public support.

Yet, this is the kind of situation we have had for years, and our general relief rolls are filled with primarily single persons or childless couples who find themselves in this kind of condition.

And I think it is time that our Nation move to do something to eliminate these kinds of ridiculous barriers. If he is unemployable, he is unemployable, and there should be a single standard of need, and we then need to provide the assistance and get to finding out whether or not we can provide the kind of rehabilitative services that might return that person to some normal mode of living.

If he happens to be on the general relief program, we have no way of being able to pay for the vocational rehabilitation he might need.

Mr. VANIK. How many people are you able to put over into the Veterans' Administration programs, those that are veterans of World War II, for example?

They have a minimum income requirement. Anybody with less than \$2,000 can get relief. That is a relief program that is operated by the Veterans' Administration.

Mr. MINTER. The numbers are not large enough to be significant, let me say.

Mr. VANIK. They are not large enough?

Mr. MINTER. No.

Mr. VANIK. I want to ask one final question.

What would be the effect of an increase in social security benefits for those who are on aid for the aged in Ohio? Suppose we give these people a benefit increase of 10 or 15 percent under social security. Will the aid to those on aid to the aged be any better off under Ohio rules?

Mr. MINTER. Not at the present time, because of course that would be deducted from the amount of the public assistance grant that they have.

Mr. VANIK. So as far as that fellow is concerned, this is an absolutely meaningless thing, unless we can make some assurance that there will be no reduction in his aid for the aged payment in an amount equal to the social security increase.

Mr. MINTER. Yes. That is why I think it is tremendously important that in both the adult program and the family assistance program, particularly in the adult program, I think we are approaching a realistic minimum standard that should be there, and then I think we ought to mandate what the State standards ought to be.

If it has to be the \$90 figure, if that should be the minimum, that would have a dramatic effect on what would happen in grants.

Mr. VANIK. I want to thank you, Mr. Chairman.

Thank you.

Mr. BURKE. Mr. Byrnes.

Mr. BYRNES. Thank you, Mr. Chairman.

Mr. MINTER. I want to congratulate you on your statement. It fortifies what I have often thought. I wish we had more local directors of welfare as witnesses, because they are close to the problems that are involved. I think we really get right down to the nitty-gritty when we get to the people who are in the day-to-day contact with the welfare people themselves, and the red tape, and other problems that are entailed.

You had in Cuyahoga County, I understand, a rather well developed program under title V. Is it?

Mr. MINTER. That is right.

Mr. BYRNES. The manpower and training.

We had a witness yesterday, Dr. Bronfenbrenner of Cornell University, who called our attention to the fact that in many of these cases of mothers, part-time employment was probably more the solution than trying to put the emphasis on full-time employment.

In your manpower training program and the final carrying of these welfare people, of these mothers, into final employment, were you able to give any appraisal of the degree to which they could be trained for part-time work, and have part-time work available to them?

Mr. MINTER. Not really. Our concentration was on full time, attempting to get persons into the labor market on a full-time basis.

We really have not had a great deal of experience in trying to work through part-time situations, and that is because the problems within the labor market itself are such that in most of the kinds of things for which you are going to be able to provide somebody some really meaningful training for jobs that they see are going to have some status, you really then are talking about employers who want full-time people, and this is particularly true because a great many of the mothers that we successfully worked with and got into the employment market came into the public arena, and by the time you lick that day-care problem on a part-time basis, you have really licked it on a full-time basis.

So we have put the emphasis on that, and really have not developed many programs to suggest this is the way someone could go out and get some part-time income.

Mr. BYRNES. I think he was thinking of the situations where you have children who are in school. The mother should probably be home when the children come home from school, so that part-time work would be more of a solution to the social problem involved than all of the emphasis that we put on full-time employment. Have you any comments on that? Have you found that a lot of these mothers were not interested in full-time employment but might have been interested if there were part-time jobs?

Mr. MINTER. I would want to underscore that our experience is that we have never had any difficulty finding mothers who want to go into the employment market.

We presently participate in a work incentive program in conjunction with the Bureau of Employment Security in Cleveland, and we have about 200 mothers who have been processed, had their physical examinations, they are all ready, their child-care plans worked out, and they are in a hold status because in fact we don't have a training program or specific program for them to go into at this point. They are just sitting there now, waiting for us to suggest, "Report such-and-such a place to begin your training."

So, you know, really it has not been necessary for us to even think about this approach.

Mr. BYRNES. Thank you very much.

Mr. BURKE. Are there any further questions?

Thank you very much, Mr. Minter. You have made a great contribution here today, and as Mr. Byrnes has pointed out, we value the testimony of a man with your qualifications.

Thank you.

Mr. MINTER. Thank you.

Mr. BURKE. Our next witness is Mr. Markham Ball.

Is Mr. Ball in the audience?

We welcome you to the committee, Mr. Ball.

**STATEMENT OF MARKHAM BALL, CHAIRMAN, COMMITTEE ON
FEDERAL LEGISLATION, HEALTH AND WELFARE COUNCIL OF
THE NATIONAL CAPITAL AREA; ACCOMPANIED BY MRS. MARY
N. BORTON, STAFF CONSULTANT, COMMITTEE ON FEDERAL
LEGISLATION**

Mr. BALL. Mr. Chairman, thank you very much.

Mr. Chairman, my name is Markham Ball. I am appearing on behalf of the Health and Welfare Council of the National Capital Area. I serve as chairman of the council's committee on federal legislation. With me is Mrs. Mary N. Borton, staff consultant to our committee, who has played a major part in the development of this presentation.

The Health and Welfare Council is the central agency for developing and coordinating the support of the private sector for health, welfare and related community services in the greater metropolitan area of Washington. It is a nonprofit organization financed chiefly by the United Givers Fund and is responsible for the allocation of all UGF funds to eligible private voluntary agencies. The council is a citizen-led organization representative of all segments of the metropolitan area.

I shall limit my statement to comments on proposed amendments to the welfare laws, primarily the proposed family assistance plan.

SUMMARY

A truly adequate welfare system would be based on the following principles:

1. All people have a right to sufficient income to meet their basic human needs.
2. All people should have an opportunity to work to support themselves.
3. Family stability should be encouraged.
4. Human dignity and the individual's right to manage his own affairs should be preserved.

5. The system must be reasonably easy to understand and administer.

We find the proposed family assistance plan a constructive step toward such a system. We believe, however, that the bill could be improved in the following ways:

1. The basic minimum payment under the family assistance plan should be raised to a level commensurate with need.
2. So long as supplementary state benefit payments are a necessary part of the plan, the bill should encourage State payments at more nearly adequate levels.
3. Assistance should be provided equally to all in need.
4. The bill should provide a single, unified system of administration.
5. Participation in work and training programs should not be compelled. Rather, the bill should provide standards to ensure that programs offer real incentives and opportunities for productive work and training.
6. The bill recognizes that adequate child care facilities are necessary if working mothers are to take advantage of work and training programs, and it takes commendable steps toward providing this care. We think, however, that the provisions for child care could be still further strengthened.

PRINCIPLES OF AN ADEQUATE WELFARE SYSTEM

Earlier this year our council reviewed the operation of the present welfare program, found the system grossly inadequate, and adopted a statement of policy on reforms that we think are necessary if that system is to do an adequate job of meeting human needs. We identified five basic principles on which, in our view, a truly adequate welfare system must be based. These principles are:

(1) *All people have a right to sufficient income to meet their basic human needs.*—There should be Federal standards of minimum benefits to assure that these needs are met in every State. We believe that minimum subsistence benefits should be available to everyone in need—those in low paying jobs, as well as the unemployed, those without families, as well as dependent children and their parents.

We also believe that adequate standards can be achieved throughout the Nation only if the Federal Government pays all, or virtually all, of these basic benefits.

(2) *All people should have an opportunity to work to support themselves.*—An adequate system of economic security should include real opportunities and real incentives for work and job training.

(3) *Family stability should be encouraged.*—No family's benefits should be reduced or denied because the family includes a parent who is employed or deemed employable.

(4) *Human dignity and the individual's right to manage his own affairs should be preserved.*—The system must encourage, not destroy, self-respect and self-reliance. Because we believe this, we believe that social services and work and training programs should be made available, but that participation in them should not be required of recipients. The goal of the welfare system must be to help people move from dependency to self-reliance. And we do not think that self-reliance can be compelled.

(5) *The system must be reasonably easy to understand and administer.*—We favor a single Federal administration and the use of the simplified "declaration method" of determining eligibility for welfare.

THE PROPOSED FAMILY ASSISTANCE PLAN

We have measured H.R. 14173 against these principles. On the whole, we find the bill a constructive step toward the kind of system that will meet the needs of our community and the Nation. We note, in particular, the following major advances:

The bill adopts the principle of a nationwide standard of minimum benefits and establishes a single national standard of eligibility for benefits.

The bill would extend welfare benefits to a great many people excluded from the present system, most notably the working poor, and thus would come closer to providing help to all who live in poverty.

The bill provides welfare recipients with new incentives to work, including the right to keep more of the money they earn without loss of welfare benefits.

The bill would encourage family stability by providing financial incentives for fathers to remain at home.

Finally, the bill offers new opportunities for job training. It recognizes that supporting services may be necessary in order to make training and employment possible, and, in particular, it provides a substantially expanded child care program for the families of participants in work and training programs.

I shall turn in a moment to specific ways in which we think the bill might be improved. We agree most decidedly with many of those

who have told this committee that the bill does not go far enough toward adequately reforming the present system. Nevertheless, we also want it clearly understood that, in our view, if the bill were passed as it now stands, we would have on the whole a much better welfare system. We are genuinely concerned that criticism by those who want more may lead to no reforms at all.

Let me now outline the ways in which we think H.R. 14173 could be improved to better meet the needs of the poor, as these needs appear to the HWC voluntary agencies who work with the poor.

(1) *The basic minimum payment under the family assistance plan, now proposed at \$1,600 per year for a family of four, should be raised to a level commensurate with need.*—We do not think anyone seriously suggests that \$1,600 per year is enough to sustain a family in a state of health and minimal decency. Even when State supplements are considered, benefit levels in most States would not nearly meet actual needs.

In the District of Columbia, for example, where AFDC payments are slightly higher than the national average, total benefits for a family of four would be only about \$2,200 per year. This is a little less than half of the amount necessary, according to a recent independent study conducted here, to sustain life at a standard of minimum decency.

Furthermore, there would still be gross disparities under the family assistance plan between amounts paid in the various States. In the States where only the basic Federal benefit of \$1,600 per year was paid, families would still be receiving less than half of the amounts paid in a number of other States.

We believe that the bill should clearly state a Federal policy to provide all Americans with an income adequate to meet their basic needs. And the bill should provide Federal benefits at levels calculated to meet these needs. Once accurate studies are made of living costs in various parts of the country, Federal benefits might be set at different levels in different areas to reflect regional differences and differences between costs in rural and urban areas.

For the time being, however, Federal benefits at the level of the Federal poverty line would be a good way to begin.

(2) *So long as supplementary State benefit payments are a necessary part of the plan, the bill should encourage State payments at more nearly adequate levels.*—First, the bill should provide financial incentives to the States to increase supplemental payments to levels commensurate with needs. There is nothing in the bill that would encourage the States to raise their present, and largely inadequate, benefit levels. The bill should require the Federal Government to share in the costs of benefit payments above present levels—at least until benefits reach levels that actually meet basic needs.

Second, the bill should provide for automatic adjustments of supplements to reflect changes in costs of living.

Third, the required level of state supplements should be measured, not by amounts actually paid in July 1969, but by the amounts of those payments adjusted to reflect changes in costs of living since payment levels were established. We suggest that section 452(a) of the bill be amended, or that legislative history be supplied, to make this clear.

In the 1967 amendments to the Social Security Act (section 402(a)

(23)), Congress directed the States to adjust their standards of need and maximum benefit levels by July 1, 1969, "to reflect fully changes in living costs since such amounts were established." Some States have made upward adjustments in standards in compliance with this direction and have raised benefits. Other States have made no adjustments. And we understand that a number of States have indeed reduced benefit levels in the face of rising living costs.

In the District of Columbia, which has adjusted neither its standard of need nor its benefit levels, standards and benefits are still based on 1953 housing costs and 1957 food and clothing prices. Benefits have been increased in the District by 13 percent in the years since these standards were established. Yet overall living costs in the District have increased more than 35 percent since 1953.

State supplemental payments should not be based simply on actual July 1969 payments, which may or may not have been properly adjusted under the 1967 amendments. To base the supplement on actual payments that may have been unlawfully low could mean that some families would receive smaller benefits under the family assistance plan than they would have received if the law were not changed—a result the administration has said it seeks to avoid.

(3) *Assistance should be provided equally to all in need.*—We know of no justification for denying benefits to individuals or married couples without children. Yet the bill excludes these people, not only from cash benefits, but also from the work and training opportunities of the family assistance plan.

The bill would not, furthermore, put the "working poor"—families headed by a father with a full-time job—completely on a parity with other welfare families. The working poor are denied supplemental State benefit payments under the bill. They are excluded from work and training programs, child-care programs, and Medicaid. Although to a lesser extent than under present law, the working poor would still be the second-class citizens of the welfare system.

(4) *The bill should provide a single, unified system of administration.*—We do not think families should have to go through two or three sets of qualification procedures in order to receive adequate benefits. This, unfortunately, is what could be required in most States under H.R. 14173—a Federal application and a Federal check for basic benefits, a State application and a State check for supplemental benefits, and perhaps a trip to yet another Federal office to register for work or training.

The bill, as we understand it, establishes a single standard of eligibility for benefits. To place administration in the hands of more than one agency seems inefficient and unnecessarily costly, and an unfair burden on the poor.

We would suggest that the States be encouraged to "contract out" to the Federal Government the task of determining eligibility and making payments. The bill should require the Federal Government to undertake these functions and to absorb all associated administrative costs, whenever requested by a State.

We suggest too that the bill fix a definite date after which all determinations of eligibility and all payments of basic and supplemental benefits shall be the responsibility solely of the Federal Government.

(5) *Participation in work and training programs should not be compelled. Rather, the bill should provide standards to insure that*

programs offer real incentives and opportunities for productive work and training.—As Secretary Shultz recently told this committee, “Studies have shown that people on welfare are little different in their attitudes toward employment than persons not on welfare.” The experience of the workers in our agencies confirms this. We think that most people want to work and support themselves.

For this reason we think the bill’s requirement that an individual accept “suitable” employment or training is unnecessary. It may, indeed, be counter-productive.

We understand and share the concern of spokesmen for the poor who fear that such provisions may be used to coerce the poor into dead-end jobs at substandard wages. We fear that the prospect of coercion, no matter how infrequently coercion is actually applied, will so alienate the poor as to defeat entirely the objectives of the work and training programs.

Furthermore, if the past decade’s experience with work and training programs has taught us anything, it is that the simple loss of a paycheck does not prevent enrollees from dropping out in large numbers. We know by now that for a work and training program to be successful, it must offer positive incentives, and must take positive steps to remove the obstacles that now bar many poor people from employment.

We suggest that the following standards for work and training programs be added to the bill, whether or not participation in these programs is made mandatory:

All training should be for specific jobs. The experience in this community and, we think, in the Nation at large, is that this is by far the best way to insure that a training program will actually lead to employment. Where possible, the “hire first” principle of the Jobs program should be applied: A trainee should be first hired, then trained on the job. In any event, training of an individual should not begin until an employer has firmly indicated his intention to hire him when trained.

Particularly in this period of rising unemployment, there is a very real risk that jobs will not be available for all people who must register for training or employment. We do not believe that people who enter training in good faith should bear the risk that there will be no jobs for them when their training is completed.

Since available training slots in the early years of the program will be far fewer than the numbers available for training, the Congress should fix priorities for entry into training programs. Even if, as we hope will not happen, some people are ultimately required to accept work or training against their will, the first to enter these programs should be people who choose to do so.

If employment is to be compulsory, a more precise definition of “suitable employment” is necessary. The bill should provide that, for a job to be deemed “suitable,” it must (1) pay the Federal minimum wage or provide a prospect of entry into a minimum-wage job within a reasonable time and (2) offer the opportunity for advancement based on ability.

The bill should direct the Secretary of Labor to choose in each locality the one or more organizations best qualified to run training and employment programs. He should be able to contract with State, Federal, and local agencies, community action agencies, and voluntary agencies.

Very often—and we have seen this happen in our area—local, citizen-led organizations are better able than a State or Federal agency to reach the people who need jobs and bring them into work and training programs.

(6) *The bill recognizes that adequate child-care facilities are necessary if working mothers are to take advantage of work and training programs, and it takes commendable steps toward providing this care. We think, however, that the provisions for child care could be still further strengthened.*—Experience with the WIN program in this city, and studies that have been made elsewhere, indicate that the greatest single obstacle that keeps welfare mothers who want to work from working is lack of adequate day care for their school age and preschool children. The voluntary agencies are deeply involved in ongoing child care programs. We believe that properly run child care programs are invaluable educational experiences for the children themselves. And we also know that if any substantial numbers of welfare mothers are to work, there must be day care for their children.

The need for child care facilities is great. The National Capital Area Child Day Care Association, one of the members of our council, has estimated that at least 12,000 children, aged 3, 4 and 5 from low income families in the District of Columbia now need day care. An additional 10,000 to 15,000 children need after school care.

Yet the number of places for disadvantaged children now available in day care centers in the District is less than 4,000. This is the situation in a community that has been a leader in providing child care facilities. The need in other communities must be as great or greater.

We would recommend the following changes to strengthen the child care provisions of the bill before this committee:

The bill should require that national standards for child care services, covering facilities, program and personnel, be adhered to in all child-care services funded under the legislation. State and local regulations cannot be relied on everywhere. In the District of Columbia, child care centers that comply with present local regulations are all too often inadequate, and at worst they are damaging to the children.

Care should be provided for elementary school children after school.

Child care should be provided for children of the working poor.

Funds should be provided for the construction of new child care facilities, as well as the renovation of old. Even with child care programs at their present level of enrollment in the District, it is increasingly difficult to find buildings that can be renovated for child-care centers. We are exploring now the possibility of building or buying low cost prefabricated units or trailers to house centers.

Programs to train day care center workers are greatly needed and should be provided. If we had the funds in the District to run all the child care centers we need, we would be very hard put to staff them. At least half of the positions in a properly staffed center can be filled by trained nonprofessionals, and experience has shown that the poor themselves, with proper training, can fill these jobs.

We have found that the entire educational program of our centers improves if the parents of the children participate in the work of the centers. A number of our agencies find that they operate with greater understanding of the needs of the poor if they employ the poor, and they find that these people are often their best spokesmen in the community. With many welfare mothers anxious to find jobs and with

child care center staff in short supply, it is only commonsense to train and employ these mothers as teachers' aides and in other jobs that very much need doing in the centers.

CONCLUSION

In conclusion, I want simply to emphasize that welfare reform is not a subject about which only the needy or only certain public officials are concerned. The private agencies represented by our council are also vitally concerned. We recognize the present welfare system and its inadequacies as basic facts of life for our community and for a great many of the people served by our agencies. We recognize that voluntary agencies can make a full contribution to the solution of the welfare problems that face us only if there are adequate public programs on which to build.

Perhaps more importantly, the very many people—ordinary middle class people—who work with the voluntary agencies and who provide their support recognize the intolerable state of our present welfare system. They, too, are vitally concerned with welfare reform.

We hope that by expressing the deep concern that we feel that we can contribute toward a chain of events that will eventually, with your help, result in a Nation where none need exist without the means to support himself in health and decency.

Thank you, sir.

Mr. BURKE. We thank you very much, Mr. Ball, for your statement. This committee appreciates the great work that the voluntary agencies are doing in the field of welfare.

Mr. BALL. Thank you, sir.

(The following was received by the committee:)

THE EPISCOPAL CENTER FOR CHILDREN,
Washington, D.C., November 12, 1969.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means, 1102 Longworth House Office Building,
Washington, D.C.

DEAR MR. MILLS: The Board of Directors of The Episcopal Center for Children met today, November 12, 1969, and unanimously endorsed the testimony of the Health and Welfare Council in support of H.R. 14173, The Family Assistance Act of 1969.

We particularly endorse the provisions for adequate child care facilities for working mothers.

Sincerely,

CYRIL V. SMITH, Jr., President.

JEWISH FOUNDATION FOR RETARDED CHILDREN, INC.,
Washington, D.C., November 18, 1969.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
Longworth House Office Building,
Washington, D.C.

DEAR CONGRESSMAN MILLS: The Board of Directors of the Jewish Foundation for Retarded Children, a non-profit, non-sectarian organization would like to offer its full support and endorsement of the testimony which was presented November 7, 1969 by the Health and Welfare Council of the National Capital area. We feel that all five principles presented in this testimony are equally important but we would like to underscore *principle number four* which states that human dignity and the individual right to manage his own affairs should be preserved. We feel that in the field of mental retardation this is a most important principle and our staff is preparing a document dealing with the principle of free choice

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in the field of the institutionalization of the severely and profoundly retarded individual. Our country was always in the forefront of assuring a humanly dignified life for all its citizens and we feel that in the field of welfare these ideals should be pursued to the greatest extent.

Very sincerely yours,

LEE E. ELSÉN,

President.

ERWIN FRIEDMAN, Ph. D.,
Director.

BIG BROTHERS OF THE NATIONAL CAPITAL AREA, INC.,
Washington, D.C., November 18, 1969.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
Longworth House Office Building,
Washington, D.C.

DEAR MR. MILLS: As a private, voluntary organization that is currently working with over 800 fatherless boys 8 to 16 years of age in the Washington Metropolitan Area, the Big Brothers of the National Capital Area wishes to record their endorsement of the testimony presented before your committee by the Health and Welfare Council of the National Capital Area regarding H.R. 14173 on November 7th, 1969.

We are particularly concerned about the desperate financial situation faced by families where there is no father in the home. These children have known the fear and insecurity resulting from loss of one parent and frequently live in unspoken dread of losing the love, the understanding, the shelter and the physical care they most desperately depend upon from the remaining parent. When these mothers have to depend upon maintaining their families through public support, they currently do not receive adequate income through governmental programs. Such programs do not even meet the level of income the Federal Government has determined, through studies carried out by the Social Security Administration, as meeting the floor—\$3,555 annually for a family of four. The proposed minimum payment under H.R. 14173, \$1,600 per year for a family of four, would continue a woefully inadequate income level.

We, therefore, strongly support the suggestion of the Health and Welfare Council that Federal benefits provided in H.R. 14173 be increased to at least the level which the Federal Government has already determined as the poverty level (\$3,555 per annum) and that the legislation include provision for further study to determine levels of Federal benefits needed beyond that amount to adjust to regional differences in cost of living.

We commend the Congress and the present Administration for their desire and determination to improve the current means of assisting those families who live below minimal subsistence income. We hope that the pending legislation can be improved to include the recommendations included in the testimony by the Health and Welfare Council of the National Capital Area.

Sincerely,

JOSEPH M. ZAMOISKI,

President.

GEORGE A. SEYMOUR, JR.
Executive Director.

FAMILY AND CHILD SERVICES OF WASHINGTON, D.C.,
Washington, D.C., December 1, 1969.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
Longworth House Office Building,
Washington, D.C.

DEAR MR. MILLS: I am enclosing a statement which I hope you can insert in the Record of the Hearings on H.R. 14173—The Family Assistance Act of 1969.

Family and Child Services of Washington, D.C., the largest voluntary family service agency in the city, strongly endorses the testimony by Markham Ball, representing the Health and Welfare Council of the National Capital Area, presented on November 7, 1969.

The basic minimum federal payment should be raised to a level of actual need and effective incentives and requirements should be included to ensure that the states meet their responsibilities for adequate supplementary benefits.

In particular, we urge the Committee to strengthen the provisions relating to work and training programs and day care facilities. If realistic training programs, real jobs and actual day care opportunities are *not* made available, this legislation will raise false expectations and do little to remedy the basic defects of the existing welfare system.

Very truly yours,

(Mrs.) B. BERNEI BURGUNDER, Jr.,
President.

ALEXANDRIA, VA., November 8, 1969.

HON. WILBUR E. MILLS,
*Chairman, Committee on Ways and Means,
Longworth House Office Building, Washington, D.C.:*

We endorse the statement on behalf of the health and welfare council of the national capital area by Markham Ball pertaining to H.R. 14173 the Family Assistance Act of 1969. We thank you for your consideration.

ALEXANDRIA BOYS CLUB.

WASHINGTON, D.C., November 13, 1969.

HON. WILBUR D. MILLS,
*Chairman, Committee on Ways and Means,
Longworth House Office Building, Washington, D.C.:*

Statement of endorsement of the Washington area Council on alcoholism and drug abuse by Frank S. Ketcham on proposed amendments to the welfare laws before the Committee on Ways and Means, United States House of representatives.

The Washington area council on alcoholism and drug abuse strongly endorses the testimony of the Health and Welfare Council of the national capital area before the House Ways and Means Committee at hearings on the bill, H.R. 14173.

Our endorsement of the HWC of testimony includes full support for the proposed changes in the provisions of the bill H.R. 14173, as recommended therein.

FRANK S. KETCHAM,
Chairman, Washington Area Council on Alcoholism and Drug Abuse.

Mr. BURKE. There being no further questions, this concludes the hearings for today, and the committee stands adjourned, to meet at 10 o'clock on Monday next.

(Whereupon, at 1:05 p.m. the committee adjourned, to reconvene at 10 a.m. on Monday, November 10, 1969.)

SOCIAL SECURITY AND WELFARE PROPOSALS

MONDAY, NOVEMBER 10, 1969

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

We have with us today our colleague from the State of Illinois, Hon. Robert H. Michel. Mr. Michel, the committee is pleased to have you here today.

STATEMENT OF HON. ROBERT H. MICHEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. MICHEL. Mr. Chairman, at this time, I would like to associate myself with the excellent, constructive measures which the President has sent to the Congress to amend the Social Security Act by increasing cash benefits across the board by 10 percent, by adding an automatic cost-of-living increase for future benefit raises, and for other, much needed improvements.

For the more than 25 million citizens who receive social security benefits, this would certainly be a meaningful and welcome approach. Not only is the gap between current benefits and fair purchasing power eliminated by the 10-percent increase, but even more important, present and future recipients of social security checks will never need to fear that their benefits will be diluted by inflation. We can be proud and thankful that the President has chosen to present this basic, structural reform to the social security system which is essential to the economic life of one of every eight of our citizens.

In addition, the proposal contains a series of recommendations for structural improvements in the social security law which will improve equity and improve administration.

I am most happy to see that the administration has recognized the continuing need to have an effective means of keeping social security programs automatically up to date, for this is what some of us here proposed in bill form as far back as 1966. The automatic adjustment proposed in this legislation would not only increase with the cost-of-living benefits being received by more than 25 million Americans, but insure that future recipients whose major source of income could well be their social insurance payments will continue to be worth as much proportionately as today. This plan assures that no more long, unnecessary delays will be interposed between the time when inflation di-

minishes purchasing power and the Congress increases the benefits to achieve the original, fair balance.

Notably, the administration is not proposing to finance the increases with increased tax rates. Rather, the amount of earnings upon which social security contributions is increased. Under the present proposal, the base is increased from \$7,800 to \$9,000. Another part of the bill specifies that this base—the amount of annual earnings counted for social security purposes—be increased from time to time to keep pace with increases in earnings levels.

The changes which this bill would make in the social security retirement test are of significant importance. This provision concerns the amount benefits are reduced if a beneficiary has substantial earnings. The provision currently in the law has been the object of widespread criticism.

The measure provides for replacing the present dollar-for-dollar reduction in benefits which now applies for earnings above \$2,880 in a year with a provision under which there would be a \$1 reduction for each \$2 earned. With this change, people would have an incentive to earn more because the more they earn, the more spendable income they would have.

The President also recommends updating the retirement test to take account of increases in earnings levels. It is proposed that the amount a person can earn in a year without having any benefits withheld be raised from \$1,680 to \$1,800 and then automatically adjusted upwards in future years as earnings levels rise.

The recommended changes in the retirement test would benefit approximately 1.1 million people. Additional benefits of \$330 million would be paid for months in calendar 1971.

The President is recommending that the social security contribution and benefit base be increased in 1972 from the \$7,800 now in effect to \$9,000. This change will very closely maintain the relationship between the base and the general level of earnings that has prevailed since the early 1950's. As indicated earlier, he also recommends that after 1972 the base be kept up-to-date with rising earnings levels in the future.

Under the present law, a widow who begins receiving benefits at age 65 is entitled to 82½ percent of the amount of the spouse's primary benefit. Under this proposal, such a widow would be entitled to 100 percent of the spouse's primary benefit. The 82½ percent rate will continue to apply to widows going on the rolls at age 62, with graduated proportions for ages above 62 and below 65.

An estimated 2.7 million people would have their benefits increased under this provision. On the average, the increase would amount to \$17 per month (in addition to what widows would get under the 10 percent general benefit increase). Additional benefit payments in the first 12 months under the provision are estimated at \$580 million.

Several important, technical amendments also strengthen the existing statute and provide a more consistent and equitable treatment for all citizens. These changes have been recommended as a result of the Social Security Administration's experience with the program as presently structured, and a careful evaluation of complaints and suggestions from many recipients and their families in recent years. As

a consequence, the changes suggested provide for consistent and technically sound administration of social security benefits.

The bill would also provide benefits for people disabled since childhood where the disability began after age 22, rather than age 18 as under present law. This bill would provide as well for the payment of benefits to the aged dependent parents of retired or disabled workers. Under present law, parent's benefits are payable only to the dependent parents of insured workers who have died. And, finally, the bill would extend the \$100 a month noncontributory wage credit for military service that was provided in the 1967 social security amendments for members of the armed services after 1967. Under the bill these credits would be available for the period from 1957, when regular social security coverage of members of the armed services began, through 1967. About 190,000 people would be immediately affected by these three proposals, and additional benefit payments in the first 12 months would be about \$60 million. Another long-standing inequity which is being corrected by the present bill is the differing treatment between men and women with regard to the computation of benefits.

Under the present law, the number of years over which a man's average monthly earnings (on which his benefits are based) and his eligibility for benefits are determined are figured up to age 65. For women these determinations are made up to age 62.

This bill proposes that the method of computing benefits for men and women be made uniform—as of age 62. As a result, the treatment of men and women workers under the benefit provisions would be the same; and the retirement benefits payable to men, payable to their wives, and the benefits payable to survivors of men who live beyond age 62 would be increased.

About 5 million people—workers, dependents, and survivors—would have their benefits increased because of the change in computing the average monthly wage. In addition, about 100,000 people—75,000 men age 62 and over 25,000 dependents—would become newly eligible for benefits because of the liberalized insured-status requirement for men age 62 and over. Additional benefit payments in the first 12 months are estimated at \$380 million.

In summary the improvements under the President's proposals in social security today are substantial and important measures. These measures not only bring benefit payments up to date but assure that they stay up to date, automatically tied to the cost of living. Finally, other important improvements in benefit protection for men workers and for widows, other have been proposed under this far-reaching legislation.

Passage of this legislation, Mr. Chairman, will have a profound impact on the life of many of our citizens. The additional security for each person who benefits by these improvements will have a ripple effect to members of his family and the community in which he lives. More people will be closer to being self-sufficient. Workers who have paid into a system during their working years will collect more equitable benefits during retirement or disability.

This is good legislation for all Americans, Republican, Democrat, or Independent. This measure, recommended by President Nixon, and I hope passed during the first session of the 91st Congress, will be remembered as a landmark in social security legislation.

I am proud to offer my unqualified support for this excellent measure.

Mr. CHAIRMAN. Are there any questions? Thank you for your statement. Mr. Michel.

Mr. MICHEL. Thank you.

The CHAIRMAN. We have with us today our colleague from the State of Texas, Hon. Graham Purcell. Would you please step forward and proceed as you wish, sir.

STATEMENT OF HON. GRAHAM PURCELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. PURCELL. Mr. Chairman, I have introduced H.R. 14538, and I would like to take this opportunity to stress the tremendous need for this bill, or any other social security improvements which would raise or do away with the present income ceiling for social security recipients.

As we all know, the current ceiling has been in existence since the Social Security Act was passed in 1935. At that time the Nation was slowly pulling itself up from the wake of the depression, and the limitation on outside income was included in the Social Security Act to encourage retirement, thus forcing those who retired out of the jobs which were needed by younger victims of the depression. In 1935 this was a timely and effective provision in the social security program. In 1969, though, 34 years later, we need not be concerned about forcing our senior citizens out of work to make way for younger people.

Today the limitation on outside income clearly penalizes those older Americans who have the desire and ability to work. Although the law allows them to make any amount once they reach the age of 72, it clearly prohibits them from receiving their benefits at the age of 65 if they desire to continue working, even on a greatly reduced schedule.

If we were to eliminate this restriction, those people approaching 65 years of age would be able to better provide for those of their retirement by retaining their social security benefits and utilizing any additional productive years as a supplement. The impact of inflation has unquestionably undermined the value of every social security check and it is past time Congress moved to protect these Americans who have given years of work to the progress of their country.

At this time social security recipients are being "taxed" at the rate of 50 percent on any income between \$1,680 and \$2,880 annually. Any income over \$2,800 is subject to a "tax" of 100 percent. How can anyone be expected to cope with a retirement during today's inflation with an outdated regulation such as this forcing them to remain in a sub-standard financial position? Right now we are forcing many Americans to answer that question, and the response is certainly not favorable.

Aside from these very tangible considerations, the effects of this "retirement test" within the social security program may well be hindering our economy in general. By removing the incentive to work—in fact, by providing a negative incentive, the country is losing the benefit of having the skill and wisdom of many citizens who have been integral "members" of the economy. In this sense, the country has a lot to gain from the elimination of this "retirement test."

In advocating the removal of this ceiling on outside income and the resulting increases in social security benefits, I am fully aware that it will mean higher costs for the entire program. Although these and other improvements might possibly be financed with the payroll tax rate increases already scheduled to go into effect in 1971, this should not be the determining factor in the passage of this legislation. If necessary, a revision of those scheduled increases should be made; this is a ledger problem we must face if we wish to provide a better income for senior citizens.

While we are currently making efforts to restore order to the economy, we must be mindful of the diminished standard of living which inflation has already forced upon so many older Americans. Those who have put so many productive years into this Nation's economic growth and development should not have to be victimized by the more transient, although very important, anti-inflationary campaign. In my opinion, an upward adjustment of benefits is imperative.

Naturally, not all people who retire have the desire or the physical ability to continue working to supplement their accumulated social security accounts. I strongly urge this committee to be mindful of their position as well. Although my bill, H.R. 14538, deals only with the amount of outside income which an individual may earn, it is not by any means the solution to all the problems older Americans face. It is however, a long step in the direction of that solution. I would hope that the favorable consideration of this improvement would provide the momentum necessary to come up with that solution.

The CHAIRMAN. Are there any questions? If not, we appreciate your coming to the committee today.

Mr. PURCELL. Thank you.

The CHAIRMAN. We have with us today Hon. Benjamin B. Blackburn from the State of Georgia. Mr. Blackburn, you are recognized.

STATEMENT OF HON. BENJAMIN B. BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. BLACKBURN. Mr. Chairman, I would like to address my remarks this morning to a provision of the old age survivors and disability insurance program, namely the income limitation on those persons who receive social security benefits upon retirement at age 65. Under this provision a man cannot even consider working part-time without endangering his social security benefits. It seems as though dependence on society is being encouraged.

When reviewing the history of this act, we find that the income limit was first placed in the act when passed by Congress in 1935. The desperate economic situation at that time made it impossible for many of our young people to obtain needed employment; and in order to create more jobs, the elderly were encouraged to leave the job market by placing an earnings limitation upon the amount a person could earn from working and still receive social security benefits.

However, I would like to point out why this argument should not be used today. First, many highly skilled people are past age 65 yet are vitally needed to provide necessary goods and services. Second, eminent gerilogists have pointed out that it is inadvisable for our

elderly to stop work since they lose all incentive if they are left home with nothing to do. Third, it is easily seen that through the use of our social security laws we have forced our senior citizens to live at the poverty level. For example, the average social security payment to an elderly person over 65 years of age is \$98 per month. Given the present social security earnings limitation, the maximum income a person can receive from social security plus outside earned income is \$3,456. This figure is below the poverty level; I believe that it is degrading the dignity of our senior citizens to force them to live at this meager existence under our present social insurance payments.

Recently, I received a letter from one of my constituents concerning the income limitation. I would like to read a portion of this letter into the testimony:

I have always worked for my living and I appreciate the opportunity of doing so. But the stipulation which has been in effect of being able to earn only \$140 per month without benefits being withheld puts you in an almost impossible situation. You can't get along on what you are getting from Social Security plus the \$140 you are allowed to earn, but you find it is hardly worthwhile to try to earn more.

As a whole, this is how the elderly of our Nation are affected by this earnings limitation: 6.6 million social security beneficiaries between the ages of 65 and 75 earned no income during 1968; 1.5 million social security beneficiaries earned an income of less than \$1,680 during 1968; 600,000 social security beneficiaries earned an income exceeding \$1,680 but received some social security benefits; 800,000 possible social security beneficiaries earned an income over \$1,680 and received no benefits.

Furthermore, Mr. Chairman, this has encouraged some of our senior citizens to evade the law. A gentleman from California sent me a letter telling me how he accomplishes this:

Should this be necessary to outsmart an unfair law? This is how it is done. We have a verbal agreement when hired as follows: Total salary \$600 per month payable \$140.00 salary (allowable) and \$150.00 car and expense allowance (not counted as S.S.). This leaves a balance of \$310.00 per month payable as a bonus in December in a lump sum. *To comply with the Social Security law, the December social security check is returned.*

Next month (Jan.) being a new year, the procedure is repeated, and I can receive 11 Social Security checks and a possible yearly income of over \$800 per month (less \$200.00 Social Security December check returned). Income tax is declared only on salary and bonus—Social Security payments and expenses can be justified as non-taxable.

I am sick of this subterfuge and believe, as you do, that my 20 years of top deductions entitles me to an old age of useful work without feeling like a cheat.

Please don't give me away, but if that's the way they want it, I will use my still active mind to find every loophole possible and educate my friends to do the same.

Also, I would like to bring to the attention of the committee a letter which I received from Mr. Wes Fleming of Dresser, Wis. In his letter which I would like to make a part of the record, Mr. Fleming explains how our senior citizens are being cheated by the income limitation.

The law states that a person cannot receive \$1,680 in "earned income." Earned income is defined to mean wages or income for self-employment. However, if the income is from interest or rental of real estate, it is not considered earned income. Thus, through our social security laws, we are discriminating against those families which would be considered middle income who have put two children through

college, probably paid a mortgage on a home, and incurred one or two major illnesses. We find that these people usually do not have the money to invest in securities and other forms of income-producing assets during their working years since they are usually trying to provide an adequate standard of living for their children.

There are those who will counter the arguments I have just presented by stating that the purpose of the social security system is to provide social insurance against the loss of income during the retirement years or disabilities. However, I feel compelled to disagree strenuously with this view. I believe that if a person pays into the system for 30 years, he has the right to receive certain benefits in return. If this person had paid into a private pension plan there would not be an income limit applied. Furthermore, if the social security system had been established with proper funding, it would be very difficult to justify any income limitation.

(The letter referred to follows:)

DRESSER, WIS., November 17, 1969.

Representative BENJAMIN BLACKBURN,
Representative from Georgia

HON. SIR: Have just read an article in the St. Paul Pioneer Press concerning what you are trying to do for old people on Social Security. Thank you very much.

I wrote a piece to this St. Paul paper a few days ago. (So far it has not been printed.) A copy of this might interest you and help you in your work.

It reads as follows:

SOCIAL SECURITY—A HOAX AND A SWINDLE—A GOOD DEAL FOR THE WEALTHY AND THE VERY POOR—AN EXPENSIVE HEADACHE FOR THOSE IN BETWEEN WHO HAVE TO WORK TO MAKE ENDS MEET

I am not against Social Security. The Medicare part of it is wonderful.

What I am against is the rotten, unfair, discriminatory laws governing the administration of Social Security.

Social Security is 'Great Stuff' until you try to collect on it. Then you find out what it really is.

We are a group of people past 65. We have no company pension. We have been self employed.

We have paid in a lot of money toward Social Security, but because we have to work to make ends meet our Social Security is taken away from us.

We understood, when this thing was first set up, that it was to help those past 65—whose earning capacity had diminished, that we need not expect to be able to live on it, that it would be a supplement to other income.

That would be fine. That is the way it should be. But that isn't the way it is.

When we have income from labor, over a lousy \$1680, then they start taking our Social Security away from us. And we don't get the \$1680. Only about \$1344. The rest the Government takes for income and Social Security taxes.

Even though past 65 we have to pay Social Security taxes to help people who never have worked and never intend to, while we keep on paying in but can collect nothing if we work enough to earn a modest income.

This \$1680 figure applies to those whose income is from labor. A person with a \$50,000 income, if it is from interest or rent can collect the full amount of Social Security—even though his money and property has been inherited.

No doubt this is as it should be. He has paid for it. He should have it.

But we have paid in just as much as he has, and if we work enough to earn a modest living—then we can not collect anything.

We want equal rights.

They tell us that after 72 we can earn any amount and also collect Social Security.

Big Deal! But who is going to hire us after we are 72. Most of us will be dead by that time.

For seven years, from age 65 to 72, we are being deprived of benefits received by others which we have helped to pay for.

We are not asking for any special privileges or special treatment. We want to earn what we are able to earn after 65 and also collect like others do. We want what we have paid for and have a right to expect.

We have worked hard all our lives. We have paid taxes, educated our children and have helped to make this country what it is today. We have never asked for or received help from anyone.

Now when we are old we are being kicked in the teeth.

Most legislators ignore our problem, as do labor unions, farm organizations and chambers of commerce. Our voting strength is not great.

People in this age group would like to keep their homes and live in the neighborhood where their friends live—in the home they have built and paid for—where the children can come home and spend a weekend once in a while.

But with taxes, upkeep and insurance costs where they are, together with the cost of fuel, telephone, light, food and clothing—we must work to make ends meet.

We like to keep a car for a small amount of driving. We have Doctor and medicine expenses. Medicare does not pay it all, not by quite a long ways.

When we work enough to meet these expenses—then our Social Security payments are completely cut off.

We have one alternative.

We can forget about meat and butter, drop our insurance, sell our home and our car—move into a small apartment and prepare to rot there. Then we could collect Social Security if we cut our earnings down to a near poverty level.

We do not want to do this. If we had fair and equal treatment we would not have to do this.

Why should we lose our Social Security just because our income is from labor? Why can't we have the same treatment given people with other income? Many of us pay \$100 a month or more to the government in income and Social Security taxes and lose our own Social Security payments besides.

People who have paid in practically nothing collect \$55 per month. There is talk of raising this to \$80, a great vote getter. But that would not help us one bit. We cannot even collect the minimum. We cannot collect anything if we earn enough for a modest living.

Seems like the modern way to get attention is to march, smash windows, tip over cars and burn buildings. We are rather old for that. Besides we don't believe in such tactics.

If enough people would write their legislators it might help.

Keep in mind that a raise in Social Security benefits will not help us. It is the amount we can earn without penalty that is killing us.

This \$1680 figure should be raised to at least \$3680. Or better still let us make what we can plus Social Security. We have paid for it. If we had put that money into insurance to take care of us in our old age we would be collecting on it. They would not ask how much we were making. We would get what we had paid for and our premium payments would stop. Why should we pay in after we are 65?

I claim the Government owes us back pay with interest for every dollar they have cheated us out of since we reached 65.

We won't be around a lot longer. Can someone help us get a square deal?

Rep. BLACKBURN. We appreciate what you are doing. I believe Hartke of Ind. and Alvin O'Konski of Wis. might give you a great lift on this.

If you consider the amount we pay in Social Security and income taxes it would almost equal the S.S. payments we should be collecting.

In other words, if we quit working and collecting Social Security it would make practically no difference to the Government balance.

Very sincerely yours,

WESLEY FLEMING.

The CHAIRMAN. We thank you for your statement, Mr. Blackburn. Are there any questions?

Our next witness this morning is Mr. George W. Young.

Mr. Young?

STATEMENT OF GEORGE W. YOUNG, CHAIRMAN, JOINT SOCIAL SECURITY COMMITTEE, AMERICAN LIFE CONVENTION, LIFE INSURANCE ASSOCIATION OF AMERICA, AND LIFE INSURERS CONFERENCE

Mr. YOUNG. Good morning.

The CHAIRMAN. We are glad to have you with us this morning, Mr. Young. We would like for you to identify yourself for our record, please, sir.

Mr. YOUNG. My name is George W. Young. I am senior vice president of the Connecticut General Life Insurance Co. in Hartford.

I am representing today the American Life Convention, the Life Insurance Association of America, and the Life Insurers Conference. These three associations have an aggregate membership of 407 life insurance companies accounting for over 94 percent of the life insurance in force in the United States. These companies also hold 99 percent of the reserves of insured pension plans in the United States. We appreciate this opportunity to express our views on the subject matter of these hearings.

The CHAIRMAN. We appreciate having you with us.

SOCIAL SECURITY'S ROLE

Mr. YOUNG. Of the topics being covered in these hearings, the life insurance business is most concerned with the proposed changes in the social security system. Over the years, it has been widely accepted that the role of this system is to provide a floor of economic security for retired and permanently disabled workers and their dependents, leaving both room and incentive for supplementation through voluntary private means. Life insurance companies agree with this principle. It is the role of our business to offer the additional life and disability insurance and pension benefits by which individuals and groups may provide benefits for themselves and their families over and above the basic benefits provided by government plans.

The social security system seeks to achieve goals for society in general as distinguished from the goals of any particular individual. The benefit formula is heavily weighted, as it should be, in favor of workers with low average earnings and thus represents a compromise between the dual objectives of equity and prevention of poverty.

In contrast to social security, the voluntary insurance system affords the individual the opportunity to create flexible contractual arrangements, based on individual equity and suited to his own needs. This freedom to plan one's own security program is a valuable right which should be preserved to the greatest degree possible.

We believe Congress should review from time to time not only the benefits levels under the social security system but also the other aspects of the system to determine whether it is properly carrying out its role. Proposals to increase social security benefits must be considered, however, not only in terms of broad social need but also in terms of their cost and the proper relationship between public and private programs. While necessary changes and improvements should be made, we cannot stress enough the fact that undue expansion of the social security system would have a far-reaching impact on voluntary private mechanisms and, in turn, on our economy as a whole.

If social security benefits were to be expanded at the expense of private insurance and pension funds, there would be a reduction in the flow of private savings and the generation of capital. It is generally agreed that, if our economy and productivity are to grow in the years ahead, there must be an increasing supply of new investment capital. Savings through life insurance and pension funds and other private savings media make a major contribution to this supply of capital.

In contrast to private savings, the social security system, quite properly, does not generate capital, but redistributes each year most of the tax revenue received. For this reason, it becomes critically important that the role of the government system be limited to clearly established social needs. This factor is of particular significance at this time when we are faced with interest rates at unprecedented levels, a situation to which the shortage of capital contributes.

Within this frame of reference, I would now like to discuss proposals which have been made to amend the social security system.

PROPOSED CHANGES IN BENEFIT FORMULA

In general, we support the administration's recommendations for changes in the social security benefit levels and benefit structure, except the proposal for automatic adjustments to take account of future cost-of-living increases.

To be more specific:

ACROSS-THE-BOARD INCREASE

We believe that a reasonable across-the-board increase in social security benefits is justified at this time on the basis of the experience of the economy since the last increases became effective at the beginning of 1968. Based upon the behavior of the Consumer Price Index since that time, the 10 percent benefit increase, recommended by the administration, would appear to be appropriate.

AUTOMATIC ADJUSTMENTS FOR FUTURE COST OF LIVING INCREASES

Many of the proposals with respect to social security include provisions for automatic adjustment of benefits and the taxable earnings base to reflect future changes in the cost of living and average wage levels. Such provisions are included, for example, in the administration's program.

We oppose automatic adjustment provisions. Social security benefits and taxes are a very important part of the economy. Both the system and its financing have become increasingly complex as additional types of benefits have been added. We believe that the extent and timing of changes in either benefits or taxes are of such importance that prior review by Congress is necessary in order to tailor the changes to fit the economic situation prevailing at that time.

Additionally, inclusion of an automatic adjustment in the social security system would be interpreted by many as an explicit acknowledgment of the inevitability of continued inflation. Any such belief on the part of the American public would be highly undesirable in that it would add to the dangerous psychology of inflation which already prevails in our economy.

We are confident that Congress will, as part of its periodic reviews of the Social Security System, continue to make necessary adjustments to reflect cost-of-living increases. These periodic reviews—and adjustments, if necessary—will help to keep the issue of inflation, and its effect on our older citizens, before Congress and the American public.

OTHER BENEFIT CHANGES

In addition to the 10 percent across-the-board increase, the administration has proposed certain other changes in the social security benefit structure. These include a liberalization in the average earnings computation for men and an increase in the benefits payable to a widow. We support these changes as being consistent with the basic purpose of the social security program.

INCREASE IN EARNINGS BASE

The administration proposes increasing the earnings base—that is, the base on which the social security taxes as well as benefits are computed—from the present level of \$7,800 to a level of \$9,000, effective January 1, 1972.

Thereafter, it proposes a system for automatic increases in the earnings base to reflect rising wage levels. I have already expressed our opposition to such an automatic adjustment procedure. Moreover, we believe the increase to \$9,000 in 1972 would be premature. Others have proposed even larger increases which we oppose. If an increase in the earnings base should be found to be necessary in 1972 or at some later date, such increase could be made at that time based on the then current situation.

Let me be more specific: We believe that the average earnings of regularly employed male workers represent an appropriate dividing line between the area in which the Government should have responsibility to provide basic retirement benefits and the area in which the individual and his employer should have responsibility to provide retirement security through private media. An increase in the present \$7,800 earnings base, in the manner proposed by the administration, is at odds with this principle. The attached chart shows the relationship between average earnings of regularly employed male workers and the social security earnings base, both historically and under the administration proposal. As the chart indicates, the practice historically followed by Congress until recently has been to limit increases in the earnings base to what is necessary to bring the base to a level which is reasonably close to the level of average earnings prevailing at the time of the increase. While this principle was not followed in connection with the last two increases, we, nevertheless, believe it represents sound policy which should be reinstated.

We estimate that the average earnings of regularly employed male workers will not even reach the present \$7,800 base until about 1972, and will not reach the \$9,000 proposed by the administration until about 1976. Thus, an increase to \$9,000, even if delayed until January 1, 1972, would bring the earnings base to a level substantially in excess of the estimated average earnings at that time. On the basis of these figures, we do not believe any changes in the earnings base should be enacted at this time—even if the effective date is deferred until 1972 as proposed by the administration.

It appears that the primary purpose of some of the proposals which would substantially increase the earnings base is to use such increase to help finance an across-the-board rise in social security benefits without making the otherwise necessary increase in the social security tax rates. We believe this is an inappropriate use of the earnings base. First, since social security benefits are wage related, an increase in the earnings base automatically entitles a worker to social security benefits with respect to the newly covered wage band. When the earnings base reaches well beyond the level of average earnings, the result is a benefit increase for those with substantially above average earnings. This is inconsistent with the basic role of the Social Security System, which is to provide a floor of protection, and would disrupt the relationship between the public and private retirement systems. However, it is a result which follows when an earnings base above the level of average earnings is used as a financing mechanism.

Second, using an increase in the earnings base as a mechanism for financing across-the-board benefit increases is an inefficient process. As I pointed out above, part of the additional revenue which is raised is drained off into providing benefits on earnings above the level appropriate for social security. Thus, only a portion of the increased revenues is available for meeting the cost of increased benefits at lower wage levels. We believe that a sounder approach is to finance higher social security benefits through the social security tax rates, where all the revenue can be devoted to financing increased benefits at the appropriate wage levels. Thus, until the level of average earnings justifies an increase in the earnings base, any increase in social security benefits should be financed through the favorable actuarial balance in the present program. Beyond that, the social security tax schedule should be drawn upon as a source of funds. Adherence to these principles will insure that the social security system remains in a self-supporting posture while at the same time financing its benefit increases in an efficient manner and in a manner that is consistent with its role in relation to private retirement media. Both of these are extremely important principles which should be followed by the social security system.

LIBERALIZATION OF THE RETIREMENT TEST

We support the proposals by the administration for increasing the amount an individual may earn without a reduction in social security benefits and for revising the formula for reducing social security benefits when earnings exceed the exemption level. We believe that these changes are not inconsistent with a sound retirement test which should be retained. The proposed change in the phase-out formula would remove an artificial incentive which now exists for an elderly individual to refuse a higher paying job. Under present law, each dollar of additional wages beyond a certain point would merely reduce his social security benefits by an equal amount. To make matters worse, the additional dollars earned are taxable while the social security benefits are not.

On the other hand, we oppose any provision for automatically raising the exemption level to reflect future increases in wage levels. We take this position for basically the same reasons we oppose automatic adjustments in the benefit levels and the earnings base. I have spelled these out earlier in my statement.

DISABILITY BENEFITS

Finally, I would like to turn to an issue that is not covered in the administration proposals, but which has been raised in legislation introduced by others. This involves the question of extending the social security disability benefit program to cover temporary periods of disability. For instance, there are proposals to reduce the benefit waiting period from 6 to 3 months and to eliminate the existing requirement that the disability be permanent in nature.

The thrust of these proposals is significant. To date, the social security program has been focused on individuals who have left the labor market—either because of voluntary retirement or because of a long-term disability. Under the proposals, the social security program would move in to cover individuals who are essentially still part of the labor market, but are temporarily off the job because of illness or an accident. This is an undesirable extension of the social security program.

The private sector of the economy is well able to furnish the protection an individual needs against loss of wages because of temporary disabilities. Currently, 70 percent of American workers are covered under programs providing varying degrees of protection against temporary disabilities. Some of these programs take the form of wage continuation plans under which the employer continues all or a part of an employee's wages for a specified length of time. Other programs utilize insurance products, many times totally financed by the employer. But the important point is that the private sector makes it possible for an individual, and his employer, to provide protection against the financial problems associated with temporary disabilities. Under these circumstances, there is no need—nor justification—for intervention by the public program.

It is no answer to say that the private programs would still have an important role as a supplement to social security disability benefits. It is important that the overall benefits payable to a temporarily disabled employee do not exceed, and, in fact, are less than, the wages he had previously been earning to preserve an incentive for him to return to work. Thus, if the social security program pays him substantial benefits in relation to his prior earnings level, there will be little, if any, room for supplementation by the private sector.

I appreciate this opportunity to present the views of the two associations. If the committee members have any questions. I shall be happy to try to answer them.

(The chart referred to follows:)

SOCIAL SECURITY EARNINGS BASE AND MEDIAN WAGES

EARNINGS BASE:

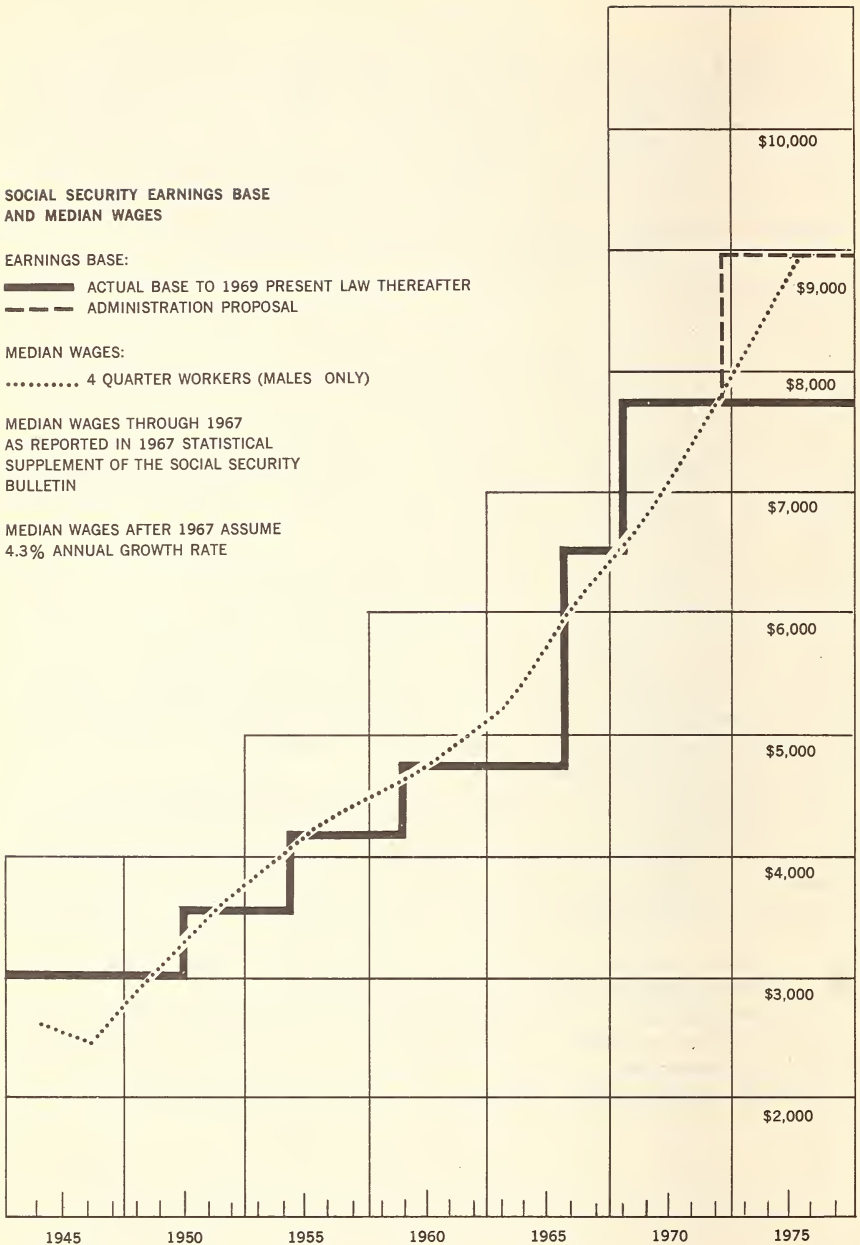
— ACTUAL BASE TO 1969 PRESENT LAW THEREAFTER
 - - - ADMINISTRATION PROPOSAL

MEDIAN WAGES:

..... 4 QUARTER WORKERS (MALES ONLY)

MEDIAN WAGES THROUGH 1967
 AS REPORTED IN 1967 STATISTICAL
 SUPPLEMENT OF THE SOCIAL SECURITY
 BULLETIN

MEDIAN WAGES AFTER 1967 ASSUME
 4.3% ANNUAL GROWTH RATE



The CHAIRMAN. We thank you, Mr. Young.

Mr. YOUNG. There is a summary statement filed with my statement.

The CHAIRMAN. We do thank you, sir, for bringing your views to the committee.

This is a summary of the statement you have just read?

Mr. YOUNG. Yes, sir.

The CHAIRMAN. That doesn't need to be in the record, but your table appended to your statement, I think, should be in the record.

Mr. YOUNG. I think it should be.

The CHAIRMAN. Without objection, it will be included.

Are there any questions of Mr. Young?

Mr. SCHNEEBELI?

Mr. SCHNEEBELI. Mr. Young, we have been given some figures by the Social Security Administrator that a person who entered the social security system in 1937 and is retiring this year, who worked at a median wage contributed roughly \$3,200 during this period of time. This is figured in his contribution plus interest at 3¾ percent. He put in \$3,200 and his benefits based on life insurance actuarial tables, his benefits as a single individual, would be about \$16,000 and for a married couple they would be over \$27,000. This ratio of almost 9 to 1, I think you will agree, is most favorable.

Have you any comments to make upon this ratio of benefits to contributions as it applies to what would be realized if it were invested in a life insurance policy, the same amount of money over the same period of time?

Mr. YOUNG. The life insurance formulas are based on a strictly equitable basis. In the social security system someone who is at the lower wage levels would receive a great deal more than his equitable share.

I don't mean by equitable what is fair, but what is actually derived from his own contributions. At the upper end of the wage scale, if the wage base were increased from \$7,800 to \$9,000, the additional contributions made would not give him anywhere nearly as favorable an increase in benefits as it would in the private sector.

Is that an answer to your question?

Mr. SCHNEEBELI. I was referring to the median, the average, which, of course, is much below your \$7,800 or \$9,000 and I was wondering how a similar investment in an endowment policy, or whatever you will, would bring to an individual. We have the figure here of \$16,000 compared to \$3,200 contributions. Could you supply for the record?

Mr. YOUNG. I think we could.

Actually, in the past, of course, when the social security system was started the benefits were initially a great deal more than had actually been purchased through the contributions of the individual who received the benefits. Social security benefits in significant amounts have been paid to retirees who have paid it in taxes, or have had paid in their behalf by their employers, very small amounts.

Mr. SCHNEEBELI. Yes. I was surprised that the median wage back in 1937 was \$900. It hardly seems possible under our present thinking, but the median wage then was \$900 and I think on the computation they figure the median wage by 1968 had hit \$5,400, but this seems like such an unusual return on the input.

Mr. YOUNG. I don't think you can look at it, Mr. Schneebeli, as really in comparison with a private pension plan.

Mr. SCHNEEBELI. I realize that.

Mr. YOUNG. It is a great return. Obviously, in a private system you can figure fairly easily the amount that compound interest would add to deposits paid on a periodic basis over the years and it certainly wouldn't be anything like the ratio you mentioned of 9 to 1.

Mr. SCHNEEBELI. Over the years I think $3\frac{3}{4}$ -percent interest is very adequate because back in those days I imagine the interest rate was 2 percent or something like that, so I think it is a very fair assumption, three and three-quarters. But I was wondering what the same investment in life insurance would pay off in relation to this 9 to 1 return.

Mr. YOUNG. I doubt if it would pay off in that way.

Mr. SCHNEEBELI. Do you have any idea what the return might be, or relatively?

Mr. YOUNG. I couldn't do it in my head.

Mr. SCHNEEBELI. Could you supply it for the record? I would be interested in knowing.

Mr. YOUNG. All right, sir.

(The information referred to follows:)

The amount of Social Security taxes paid since 1937 by a man earning each year the median wage for male workers accumulated at $3\frac{3}{4}$ percent per year, was calculated to be approximately \$3200 (this does not take into account the matching amount paid by his employer). Using current purchase rates for group annuities, this accumulated sum would provide a monthly benefit beginning at age 65 of about \$30. It should be emphasized that, as developed in the exchange between Mr. Schneebeli and Mr. Young, it is virtually impossible to make a meaningful comparison between the latter figure and the amount such an individual, let alone his dependents, might receive from the Social Security system. This stems from several factors among which are the benefit design of Social Security which provides both for a higher proportion of wage replacement at lower income levels and for additional benefits for dependents, variations in the extent of employer contributions toward the cost of private pensions, and differences between the funding method used by Social Security and that commonly used by private pension plans.

Mr. SCHNEEBELI. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Corman?

Mr. CORMAN. I wanted to ask the gentleman from Pennsylvania—I didn't understand the figure—how much would the average worker have contributed between 1937 and 1969?

Mr. SCHNEEBELI. He would have put in an amount of money which with the $3\frac{3}{4}$ -percent interest added would have amounted to \$3,196, or something like that. I am figuring \$3,200 is what the median wage earner would have put in during that period of time.

Mr. CORMAN. You mean if he had worked all that period of time from 1937 to 1969 at the median wage?

Mr. SCHNEEBELI. Yes. The median wage back in 1937 was \$900 and it was 1 percent, you see, so at that point—

Mr. CORMAN. It is fairly low. But in 1969 the contribution of employer and employee was—

Mr. SCHNEEBELI. Excuse me. This is only the employee contribution because as an individual that is the way the individual looks at it, "What did I put in?"

Mr. CORMAN. I see. I was surprised at the low figure.

Mr. SCHNEEBELI. Yes, I was, too.

Mr. YOUNG. Of course the contribution by the employer helped to provide this.

Mr. SCHNEEBELI. That is right. That doubled the amount of contribution.

Mr. CORMAN. May I ask the witness, do you know how many people are presently drawing private pensions; that is, exclusive of all Government pensions? How many people are drawing private pensions?

Mr. YOUNG. I don't have that figure, sir.

Mr. CORMAN. Do you have any estimate at all?

Mr. YOUNG. I wouldn't want to give one off the top of my head. It is a statistic which we can get very readily.

(The information referred to follows:)

The most recently published figures concerning the extent of coverage under pension and retirement plans are for the year 1967 and are contained in the January, 1969 "Tally" published by the Institute of Life Insurance.

In 1967, somewhat more than 3.5 million people were receiving pension benefits under private retirement plans. In addition, nearly 2 million people were receiving benefits under retirement plans administered by the government which include the railroad retirement plan and the Federal, state and local plans for civilian employees. During the same year more than 13 million retired workers were receiving old age or disability benefits under Social Security.

The amounts of benefits paid during 1967 were about \$4.25 billion under private retirement plans, about \$4.4 billion under government administered plans and about \$13.9 billion under Social Security. In addition, Social Security provided benefits for dependents and survivors.

There has been a tremendous growth in private retirement plans since 1950. During the latter part of this period, from 1957-1967, the number of active workers covered by private retirement plans has increased over 50% from 18 million to 27.5 million; the number of workers receiving pensions has increased over 180% from 1.2 million to 3.5 million; the benefits paid to retired workers has increased over 270% from 1.1 billion to 4.25 billion; the assets accumulated to provide for future benefits increased nearly 190% from \$36.2 billion to \$104 billion.

I quote these figures to show that private pension plans are currently providing a substantial number of retired workers a substantial amount of benefits and that the number of people receiving benefits and the amount of benefits received is growing rapidly as private pension plans mature.

Mr. CORMAN. If you can supply it for the record, I would be very interested. I gather from your testimony that you anticipate most people are going to have their social security supplemented by a private pension system.

Mr. YOUNG. We would hope that those with above average incomes and a lot of them with average incomes would be able to supplement their social security payments through their own private savings. We know that private pension funds amount to something over \$100 billion in reserves at the present time and the private pension system has been growing very rapidly in recent years so this can generate a lot of pension payments in the future.

At the present time there are a lot of people receiving private pensions, but it is nothing like the number that will in the future.

Mr. CORMAN. I wonder if there would be any statistics available as to how many people who are living on social security benefits have additional sources of income, how many are living on their social security benefits and whatever supplemental earnings they are permitted?

Mr. YOUNG. I have seen those figures, sir.

Mr. CORMAN. If you could supply them for the record, it would be helpful.

Mr. YOUNG. I think the Social Security Administration has presented those figures.

Mr. CORMAN. I take it when we started the social security program the median wage was \$900 a year, and we fixed the amount of coverage at \$3,000. We apparently were better than 3 to 1 over the median wage when we started, whereas now, although it is a little bit difficult to see what the median wage is——

Mr. SCHNEEBEL. It is about \$5,400.

Mr. CORMAN. The median wage today is \$5,400?

Mr. SCHNEEBEL. It was last year.

Mr. YOUNG. In my figures when I referred to the median wage, I meant the median wage for male workers with either wages reported in each of the four quarters of the year or with reported wages equal to the prevailing maximum. This median is, of course, higher than the median for all male workers that is being discussed, since the group of all male workers would include many students or retired men with very low earnings. Our figures were intended to be used as a measure of average prevailing wages of men working on a full-time basis, which we think is a reasonable measure for determining where to set the earnings base.

Mr. SCHNEEBEL. No further questions.

The CHAIRMAN. Any further questions of Mr. Young?

Thank you, Mr. Young, again, for coming to the committee.

Mr. YOUNG. Thank you.

The CHAIRMAN. Mr. Parish.

Mr. Parish, we are pleased to have you with us today, sir, and if you will identify yourself for the record, we will be glad to recognize you.

STATEMENT OF NED F. PARISH, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS; ACCOMPANIED BY JAMES D. KNEBEL, ASSISTANT EXECUTIVE VICE PRESIDENT; AND EUGENE W. AUNE, VICE PRESIDENT, ADMINISTRATION, TEXAS BLUE SHIELD

Mr. PARISH. Thank you, Mr. Chairman.

My name is Ned F. Parish. I am executive vice president of the National Association of Blue Shield Plans. The association consists of 72 active member Blue Shield plans in the United States and Puerto Rico, including 33 plans which are medicare part B carriers, and which are responsible for service to about 60 percent of the program's beneficiaries. Sixteen of our member plans are carriers for title XIX programs.

With me are James D. Knebel, assistant executive vice president of the association on my right, and Eugene W. Aune, vice president, administration, of Texas Blue Shield on my left.

The CHAIRMAN. We are pleased to have all of you gentlemen with us, and you are recognized.

Mr. PARISH. Thank you, sir.

Both of these gentlemen have experience in depth with titles XVIII and XIX, and are here to make that experience available should members of the committee have questions.

As an association representing carrier plans, we are naturally concerned with some of the items on the committee's calendar. We would like the privilege of submitting separately written comments on several points, including the health cost effectiveness amendments. These, Mr. Chairman, have been submitted as appendix D to our testimony.

The CHAIRMAN. Do you want them in the record following your statement?

Mr. PARISH. Please.

The CHAIRMAN. Without objection, they will appear in the record following your statement.

Mr. PARISH. To the extent that it may be helpful, the specialists of the association's staff will be available to your staff to assist in any way possible with the technical implications of those or any other items.

Today, however, I want to address myself to the broader question of program administration. I would like to make available to you the results of a great deal of work that we have done to show how full use can be made of the experience and capabilities of the private sector in support of government programs. I will try to explain what might be accomplished for the programs and for their beneficiaries through determination to use fully the available resources. But before developing that matter, I want to comment upon the matter of cost containment in the current administration of medicare.

There have been allegations that medicare and medicaid carriers have made payment for professional services at levels higher than those that prevail in their private business. If this were true, it would reflect a serious situation. It would mean that physicians were exploiting the programs, and that the carriers, in turn, were remiss in applying controls. It has been a matter of urgent concern to us to determine whether there is substance in the charge.

First, it must be understood that the comparison has to be between similar techniques of payment. Blue Shield's techniques include methods other than the customary, prevailing, and reasonable mechanism. Furthermore, the payment restrictions imposed by the previous Secretary of HEW have modified the basis of payment for medicare itself during 1969. But comparison is possible between Blue Shield customary, prevailing, and reasonable charge programs and payments prior to 1969 by the same plans who are also medicare carriers.

NABSP has studied the payment data for calendar 1968 of nine representative carrier plans using the customary, prevailing, and reasonable charge mechanism for significant portions of their private business. Collectively, these plans represent 35 percent of the total Blue Shield medicare enrollment, 33 percent of medicare benefits administered by us during 1968, and 39 percent of Blue Shield claim receipts during the same period. We feel that this study is significant, and we are submitting it for the record as appendix A.

Ten surgical procedures were examined, chosen as indexes of charge levels, and for equivalence of surgical difficulty and frequency above and below the age level 65. These 10 procedures occurred 41,795 times in the survey sample. On the basis of this study, which has been cross-checked for validity and for effectiveness of the sample, we conclude that no statistically significant difference existed between the charge levels allowed by Blue Shield carrier plans for medicare and for their private enrollment, using a comparable method of payment. The same is true for medicaid where the basis of payment is comparable.

Admittedly, this study is a sampling. Further studies will be done. However, its validity has been thoroughly tested and confirmed, and it is, for the moment, the most reliable information in existence and

available to us on the question of comparative payments. Accordingly, we conclude that our plans are administering the program conscientiously, and with due regard for the need to conserve funds in the program.

I would like to turn now to the question of how the government can make additional use of the resources of the private sector in its efforts to bring proper financing for medical care to all people.

We read the financing provisions of title XIX as encouraging the use of carriers. This option has not been exercised by the majority of States and, in our view, the program is weaker for this.

The legislative purpose, as we interpret it, is that medicaid patients shall not be set apart from the rest of the population with respect to their right to health services nor their means of getting those services. They are to participate in what has been called the mainstream of medical care. We believe that some setting apart is inevitable unless the medicaid beneficiary does in fact use the same methods of financing that the rest of the people do. And, despite the real and imagined shortcomings of health coverage, the vast majority of Americans do finance portions of their care through health insurance and prepayment.

We believe that a primary reason for the limited use of carriers has been that there has been no document available to spell out both the functions of the carrier and its relationship to the single State agency. We think there has been need for a formalized approach to the problems of budgeting, utilization review, the pricing of services, the reporting of information, and other areas in which a clear understanding and assumption of responsibility are essential to the proper execution of the carrier role.

Blue Shield and Blue Cross have developed such a document. I am submitting for the record, as appendix B, a model contract worked out for the guidance of our member plans who contemplate a role in title XIX. The contract was developed as a membership service. It was not requested by the Government, nor was its development paid for with Government funds. It has, however, been submitted to the Government, and has been adopted by the Department of Health, Education, and Welfare as a guide for all future prepaid contracts under title XIX. It has been distributed to State agencies (SRS-MSA-OC, May 13, 1969) as the method of choice for controlling costs and the utilization of services. I should like to call this contract to your attention, and to ask your consideration of it as a means of focusing the resources of the private sector upon the problems of Government programs.

Parenthetically, I want to make this point. We are discussing our own work, and we will naturally refer to Blue Shield. However, I do want to make it quite clear that at no time have we sought an exclusive role in either medicare or medicaid. We are attempting to illustrate the capability of the private sector. We are firmly of the opinion that competition between private carriers challenges their ingenuity and creativeness, and benefits both the patient and the source of finance.

As we view the technical problems of implementing title XIX, they are maintenance and application of eligibility records; determination of proper payment to the provider of services; monitoring utilization not only to contain costs, but to assure quality; prompt and accurate processing of claims, auditing of provider claims; and developing and

reporting information regarding the program so that it can be properly evaluated and an accounting made of public expenditures.

There is some feeling that if a computer is big enough, and its operator is well-intentioned, these problems will be solved.

Unfortunately, Mr. Chairman, that is simply not true. Electronic data processing is extremely important to the delivery of good coverage. But it is a tool, designed to support the functions of people trained to attack the problems of a program. Our plans have assembled such people. Our contract is quite specific with respect to the duties we would expect to execute to resolve each of these problems. To illustrate, let me examine with you the subject of utilization review, which I choose because of its importance to cost, a major factor in any program.

Ability to execute effective utilization review is required of any plan if it is to use the Blue Shield trademark. We have a highly sophisticated utilization review model, criteria for which I am submitting as appendix C.

A Blue Shield utilization program will include an ongoing audit of claims, with statistical reports; a corrective program including staff review, professional review, documentation, and an appeal mechanism; a program of education to acquaint physicians and the public with the need for attention to utilization; and a reporting system to show case trends and gauge both the effectiveness of the system and areas in which more emphasis is needed.

Title XIX imposes duties upon the State agency's medical unit that cannot be delegated within the law, and which require a considerable statistical base for the auditing of diagnostic, treatment, and utilization data. The model contract is quite specific with respect to the carrier's role in support of the medical unit. It calls for the provision of basic data files and automated information files, to include information on individual identification; individual medical care and treatment; out-of-hospital care and service; drug utilization; home health services, and laboratory, X-ray, clinic, and transportation services. Additional information will deal with practitioners, pharmacies, hospitals, and other patient care facilities. Data specific to medical care utilization include identification information by case, diagnostic studies, treatment studies, surgical procedures, drug utilization and cost studies, length of stay by hospital and nursing home, and utilization reports. Summary reports are posted periodically, as appropriate.

Again, I want to caution that statistical information alone is almost never adequate as a sole determinant of the quality of utilization. It requires support by professional and provider relations, by knowledge of area resources and practices, by onsite investigation where necessary, and by human interpretation. In these areas, the experience and resources of the carrier can be most valuable, not only in monitoring utilization, but in encouraging use of the most economical resources.

The private sector has invested great effort in other areas important to the program. An example is Blue Shield's method of determining usual, customary, and reasonable charges, which places a premium on the carrier's own ability to improve its system and its supporting services.

Obviously, one of the greatest challenges in a program operated through appropriation is committing the proper amount of money. Prepayment of the program offers a practical solution. It can eliminate the need for emergency supplemental appropriations, while guar-

anteeing that Government funds are used only for Government programs. It does this by injecting some flexibility into the appropriation cycle, compensating for gain or loss in the rate for the following period. The advantages in terms of planning are obvious.

This approach is working well in practice. It is accompanied by another advantage at least as important. The patient becomes a participant in the normal means of health financing. He is not set apart from the rest of the community and he is better equipped in his own eyes to become a part of the mainstream as the law intends.

In transmitting the model contract to the States, the Medical Services Administration described it as, and I am quoting:

Providing for maximum utilization of the private and public insurance sector of the economy in the administration of Medicaid.

It called particular attention to—and again I am quoting—

the manner in which all relative functions and responsibilities are fully disclosed and are spelled out in such a way as to insure that both parties of the contract understand fully what is expected of the other; the way in which the model contract safeguards the single state agency concept * * *; the basis for computing prepaid charges; the basis for making payments to providers; the content of claims for services provided; the contractor's audit of individual claims; the basis for utilization review and re-certification of medical need; the contractor's accounting allocations and operators; the content of definitions, and in general—the “comprehensiveness” of the model contract's provisions.

The problems that medicaid faces today—how to process claims efficiently, how to conduct effective utilization review, how to maintain accurate and current history and eligibility files, how to develop effective provider relations, how to budget benefit and administrative costs—all of these are problems the private sector has been coping with for 35 years. We feel that our experience can and should be brought to bear on the problems of the program.

I would now like to refer to title XVIII. We have testified in the past that in our opinion the program would benefit from more administrative latitude on the part of the carrier. We have been critical of what we considered overmanagement on the part of SSA.

I am happy to be able to report some improvement in this picture. There has been increasing involvement of the carriers in the formulation of policy, for example in the development of the forthcoming utilization review guidelines and in defining the role of SSA's onsite representatives. A more effective relationship is evolving between SSA and the carriers.

Nevertheless, the effectiveness is relative, and the Government's fundamental position still seems to be, that a carrier is somehow different from the usual Government contractor in that it is to be told not only the specifications of the result, but specifically how to achieve that result. Such an approach handicaps the carrier, the Government and the taxpayer. This committee is clearly concerned with the plight of those who cannot finance their own health coverage. Surely the health carriers, who are willing and anxious to cooperate, should be enlisted in the same concern. But our cooperation can be most effective only to the extent that we are called upon to use the abilities we have spent years developing. How do we suggest this be accomplished? We believe that the contractual approach we have described and submitted is the best way to do this in any Government program. If the private sector were permitted to exercise its creativeness in maintaining records;

determining payments; monitoring utilization; processing claims; auditing, reporting; and accounting, and if it were permitted to do this so that the normal incentives to productivity provided their own rewards for economy and efficiency, the costs and some of the administrative frustrations of Government programs could be reduced. We would hope that this committee would agree, and would see fit to encourage, wherever possible, the broader use of our capacities.

Mr. Chairman, this concludes our oral testimony. We appreciate the opportunity to appear before the committee, and we will be glad to attempt to answer any questions you may have.

Thank you, sir.

The CHAIRMAN. Mr. Parish, in order that I may properly understand, what you have asked to be included in the record is this material that you have appended to your oral statement.

Mr. PARISH. That is correct, sir.

The CHAIRMAN. All right. It will appear at this point in the record. (The material referred to follows:)

APPENDIX A

PHYSICIAN FEES: A COMPARISON OF GOVERNMENT AND NONGOVERNMENT CARRIER PAYMENTS

Edward S. Mills, Ph.D
Theodore F. Lake, MBA*

*Research Economist and Research Statistician, National Association
of Blue Shield Plans, Chicago, Illinois

The authors wish to express their appreciation to the Blue Shield
Plans which supplied data for this research and to Louis F. Hayes, M.D.,
of the Michigan Medical Service for his professional evaluation of the
surgical procedures studied.

Public attention has recently been focused on medical services, the availability of high quality medical care and the charges for these services. Particular attention has been directed to the various payment and prepayment mechanisms.

Of specific concern to those directly involved with the health care delivery system, is what some believe to be payment disparities. Some observers have suggested that providers of health services receive higher payments from prepayment agencies for services rendered to patients covered by government financed programs than for similar services performed for private contract patients.

Recognizing the inability of many persons requiring medical attention to meet the market price of health care services, physicians have traditionally practiced first degree price discrimination in charge patterns basing their fees on the "ability to pay" principle. By charging the more affluent patients higher fees, physicians were able to compensate for professional services rendered to charity patients. Despite wide use of this practice by physicians, medical care utilization patterns have historically exhibited a direct relationship to individual income.

Many recipients of charity medicine intuitively believed that the care which they received was of lower quality than that received by noncharity patients. Indeed, few persons in any income group fully equate a free service with one which carries a price tag. The very character of teaching hospitals creates similar feelings, instinctive though they may be, for treatment by interns and residents in a demonstration setting raises questions concerning the attitude of student physicians and established practitioners viz a viz their charity patients.

In 1965, Congress acted to improve both the quality and quantity of medical care available to the aged and indigent. Passage of the Medicare and Medicaid titles XVIII and XIX of the Social Security Amendments of 1965, established the federal government as an active participant in the national health care delivery system.

Rather than constructing a new health care delivery system, or radically restructuring the existing one, a mechanism was developed which permits the impecunious to enter the mainstream of medicine on the same basis as higher income persons. Indirect government payment of physician charges for services rendered low income persons makes it more difficult to identify charity patients, and reduces the stigma associated with that status.

Established third party reimbursement mechanisms, including Blue Shield Plans and commercial insurance companies, were awarded contracts to pay claims for professional services rendered, at physicians' "customary" levels. As a result of these programs the volume of "charity" medical care provided without charge by physicians has declined.

Inflation

The Medicare program implementation in 1966 resulted in sharp increases in medical system utilization, without corresponding increases in health care delivery system capacity. Coincident with this dramatic change in demand for medical services was a similar demand shift for goods and services generated by the initiation of several "War on Poverty" programs and the escalation of the Viet Nam War. In time, these fundamental demand changes pervaded the entire economy, producing a classic inflationary system of a fully employed economy faced with rising effective demand. The problem was exacerbated by strong labor and producer groups in the economy which pushed up costs by virtue of advantaged monopolistic market positions.

The difficulty of estimating Medicare and Medicaid program¹ expenditure has required repeated upward budget revisions which, coupled with the rapid increase in health care costs since the enactment of the programs, have drawn attention to physician fees. Some observers have speculated that physicians have increased their fees for patients covered by the new government programs more rapidly than those for nongovernment patients, in an opportunistic fashion. It has been presumed that Medicare and Medicaid carrier fee payment patterns exhibit this type of discrimination as well.

Study Design

Drawing upon the data resources of the National Association of Blue Shield Plans, an investigation was made of the relative Blue Shield Plan dollar payments for government and nongovernment covered physician services. A number of Blue Shield Plans carrying Medicare and Medicaid programs during 1968 which had an operational private business program with payment mechanism similar to that prescribed for Medicare were chosen.² The plans supplying data for the study paid 33% of the total benefits administered by the 33 Blue Shield Medicare carrier plans during 1968.

1.

Staff, Committee on Finance, United States Senate, Staff Data Related to Medicaid-Medicare Study, Washington: U.S. Government Printing Office 1969, pp.4-5, 10-11.

2.

The nine Blue Shield Plans responding to the request for data were: Alabama, California, Delaware, Kansas, Michigan, Minnesota, Pennsylvania, Rhode Island and South Carolina. These plans represent 35% of the total Blue Shield Medicare enrollment, and 39% of Blue Shield claim receipts 1968.

It has been alleged that physician payments for services provided under government programs are significantly higher than those paid under all private coverage contracts.³ Before considering the allegation, it is important to first examine the different types of payment mechanisms employed by carriers for government and private programs.

Under the Medicare program a physician's fee is paid in full, subject to deduction and coinsurance factors, if it is the fee which he "customarily" charges and which generally "prevails" for his specialty within the socio-economic area. Early Blue Shield contracts were of two basic types. The indemnity fee schedule approach fixed upper limits on physician reimbursement which required the provider of care to collect from the patient any difference in his fee and the Plan payment. The "service benefit" concept provided fee payment based on the subscriber income level. No valid fee payment comparison may be made among these dissimilar payment techniques. Fee payments on behalf of Medicare beneficiaries may exceed fee schedule or service benefit payments for those who cannot afford the necessarily higher premium of private "paid in full" coverage.

In recent years, Blue Shield Plans have introduced "usual, customary and reasonable" (UCR) contracts which incorporate a fee payment mechanism similar to that utilized under Medicare, although deduction or coinsurance clauses are seldom included. Valid comparisons of government program and Blue Shield payments to physicians under private contracts are possible, if UCR data are utilized.

Data for the year 1968 were studied to eliminate the influence of the temporary reinterpretation of the Medicare fee determination procedure, instituted by the Social Security Administration in January of 1969.

³ Staff, Committee on Finance, United States Senate, Staff Data Related to Medicare-Medicaid Study, page 32.

Ten representative⁴ surgical procedures were selected, and actual physician charges, and the charges "allowed" by the Plan were obtained. The "allowed" physician charge is the amount judged reasonable by the Plan.

Medicare deductions and coinsurance factors as well as individual state medical program regulations may result in a somewhat lower Plan payout figure.

Results

Government and private UCR program comparisons were developed from the data, employing standard statistical techniques, testing the validity of the charge differential allegations. The results of the testing procedures indicate that there are no statistically significant differences in Plan charge allowances among the three programs.

The survey included nine of the 33 Blue Shield Medicare carriers and covered ten surgical procedures which occurred 41,795 times in the survey sample. Plans submitted data from their highest charge economic-geographic area.

Validation Methodology

The study tested the null hypothesis: there is no significant difference in the average charge allowed by Plans among its Medicare,

⁴ Based on considered medical opinion, the surgical procedures utilized in this study are presumed representative of services regularly performed by physicians. Further professional evaluation reveals no significant performance difficulty for these procedures associated with patient age. Therefore, we may reasonably anticipate the same physician payment for services rendered to patients over and under 65 within a particular homogeneous area. In the data recording system employed by member Plans, each procedure is assigned a four digit identification number which is included in the computerized claims history file maintained by each Plan. Survey data was collected on the basis of these procedure codes. Descriptive medical terminology and professional evaluative comment for each code is contained in Appendix A.

Medicaid and private UCR business programs. The survey questionnaire requested frequency and total dollar allowance for each procedure.⁵ The mean charges of each of the ten procedures and each of the Plans sampled were calculated.

An analysis of variance (F Test) was initially employed to test the hypothesis. This test was applied two ways for the five Plans that carried all three programs.⁶ First, combining five Plan data by procedure, each procedure was tested to determine whether any significant difference was evident among the three programs. The resulting F values are shown in Table 1.

Table 1

Analysis of Variance for
Ten Surgical Procedures
5% Critical F Value 3.88

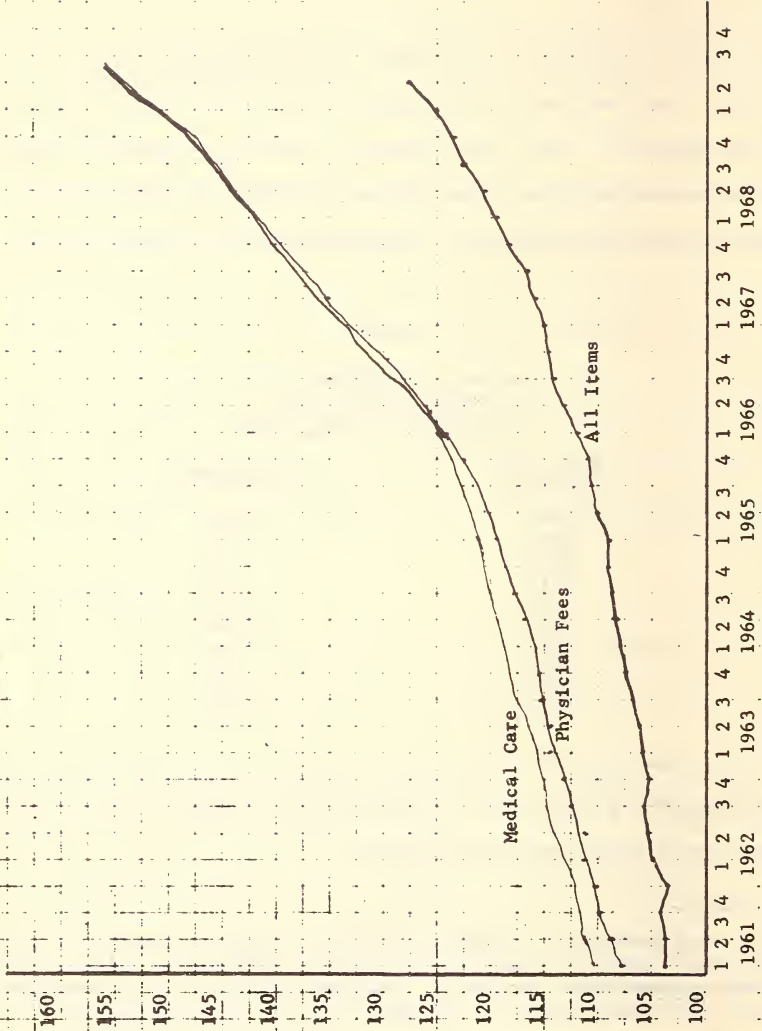
<u>Procedure</u>	<u>Calculated F</u>
0445	1.68
0806	1.11
1075	.72
3115	.69
3375	1.49
3515	2.16
3631	1.79
4321	.92
4631	1.03
4917	1.30

Second, combining ten procedure data by Plan, each Plan was tested to determine whether a significant difference existed among the three programs. The resulting F values are shown in Table 2.

⁵ Plans were instructed to modify the data by eliminating extreme high or low "token" charges on Medicaid and private UCR data, in order to obtain a more representative statistic. Medicare by SSA regulation requires removal of these extremes in the administration of this program.

⁶ Medicare, Medicaid and private UCR.

CONSUMER PRICE INDEX



Source: Monthly Labor Review

Table 2

Analysis of Variance for
Five Plans
5% Critical F Value 3.35

<u>Plan</u>	<u>Calculated F</u>
A	0.3
B	4.80
C	.01
D	1.25
E	.07

Results in Table 1 indicate no significant difference in the mean allowed charge for all ten procedures at the 0.5 significance level. The hypothesis was rejected for Plan B at the 0.5 level; however, the hypothesis was acceptable at the .01 level (5.49 critical value) of significance.

The hypothesis rejection for Plan B is not surprising. The mean Medicaid charge for all 10 procedures was substantially below those for Medicare and UCR contracts, because the state bureau which supervised Medicaid prescribed a low payment level fee schedule for the program.

In order to utilize the collected data fully, small sample technique (T Test) was employed testing the absence of difference in Medicare and private UCR mean allowed charge. The test was performed two ways: first, it was applied to each procedure, with results presented in Table 3.

Table 3

T Test for Small Samples
Ten Surgical Procedures
5% Critical Value 2.131

<u>Procedure</u>	<u>Calculated T</u>
0445	+.0200
0806	-.3836
1075	-.6714
3115	+.0103
3375	-.0492
3515	-.5318
3631	-.8926
4321	-.3647
4631	-.2115
4917	-.3962

The results once again indicated that there was no significant difference in mean charges for each procedure between the two programs in the nine Plans. The calculated T values for each procedure were well below the critical value at the 5% significance level. Next, the test was applied to each Plan which carried Medicare and private UCR contracts. The results of this test are shown in Table 4, below.

Table 4

T Test for Small Samples
9 Blue Shield Plans
5% Critical Level 2.101

<u>Plan</u>	<u>Calculated T</u>
A	+.0573
B	-.3983
C	+.6251
D	+.4594
E	+.1385
F	-.1842
G	-.4149
H	+.1617
I ⁷	-----

Conclusions

No meaningful comparisons of government and nongovernment carrier reimbursement performance can be made unless the private coverage payment mechanism is comparable to those of the federally funded program.

When Blue Shield Plan UCR data are compared to government program data, it is observed that there is no statistically significant difference in carrier payments made during 1968 by the nine Blue Shield Plans responding to this survey.

Indeed, the nation is experiencing a serious generalized inflation and the cost of medical care has risen dramatically. However, Blue Shield Plans have not contributed to the inflation process by discriminatory professional fee payment practice which would expand government program expenditures.

7.

Plan I submitted Medicare information only.

APPENDIX A

Descriptive medical terminology and professional evaluate comment follows for each code:

- 0445 Excision of cyst, fibroadenoma, or other benign tumor, aberrant breast tissue, duct lesion or nipple (including any other partial mastectomy) unilateral
- This sex related procedure (female only) has approximately the same incidence in patients over and under 65 years of age.
- 0806 Fracture, radius, distal end, Colles (including ulnar styloid). Simple closed reduction, without manipulation.
- This procedure has relatively higher frequency at age extremes, i.e., high incidence under 21 and over 65 years of age. There is no difference in degree of performance difficulty associated with patient age.
- 1075 Excision of intervertebral disk with spinal fusion (one surgeon)
- This course of treatment is most common in 30-40 year age group, and less frequent in older groups. There is, however, no difference in degree of difficulty of performance.
- 3115 Subtotal gastrectomy, with or without vagotomy
- The frequency of occurrence of ulcer requiring this surgery is the same for over and under 65 groups, but surgical treatment is less likely for the older group.
- 3375 Hemorrhoidectomy, internal or internal plus external
- The frequency of occurrence is the same in both groups, and there is no difference in degree of difficulty of performance.
- 3515 Cholecystectomy
- The frequency and difficulty are the same for over and under 65 groups, although this surgery is more common for females.
- 3631 Hernioplasty, Herniorrhaphy; herniotomy - inguinal, unilateral
- Frequency and difficulty are the same for this 95% male procedure

- 4321 Transurethral electroresection of prostate, including control of post-operative bleeding, complete

The frequency of the over and under 65 groups is about the same, though the 40-65 age group experience higher frequency than over 65. Because this treatment is to a degree elective, there is possibility of coverage induced utilization by men over 65 who have lessened employment demands on their time. There is no difference in degree of surgical difficulty.

- 4631 Vaginal hysterectomy, with or without pelvic floor repair

This female procedure is required less frequently for those over 65, although there may be an element of benefit utilization influence, performance is no more difficult for the over 65 age group, and may in fact be less difficult. Malignancy is less frequent over 65.

- 4917 Thyroidectomy, subtotal or partial

About 65% are performed on females, more often under age 65. There is no difference in degree of difficulty between groups.

APPENDIX B

MODEL PREPAID AGENT CONTRACT - GENERAL DESCRIPTION

The Model Prepaid Agent Contract breaks down into nine Articles. Article VI and Article IX, together with their Addenda, contain Prepaid Charges and Final Accounting provisions, respectively. These are the bases for the characterization of the contract as a "Prepaid Agent Contract" between the Plan and the State Agency.

The Plan duties set forth in Article III, Section A are much the same as those under the Model Fiscal Agent contract. However, the more flexible and therefore less predictable duties in terms of cost, which are not included in the rate, are treated specially under Section A paragraph 14. These added administrative duties would be free-standing i.e., would require agreement as to performance and reimbursement to the Plan on a cost basis. Article VIII provides for reimbursement for these items under Blue Cross and Blue Shield Accounting Manual traditional guidelines included as Addenda 7 and 8 to Article V.

Article VI - Prepaid Charges - provides for a premium per person (paragraph 1) payable on the 20th of the month preceding the person's coverage (paragraph 4). A two month reserve premium deposit is provided for in Article VI, paragraph 7. Premiums and deposits will be allocated between Blue Cross and Blue Shield Plans by filling in the appropriate blanks.

The Addenda to Article IX provides the experience rating formula. It balances prepaid charges, including the two month reserve, against:

1. Benefit payments and incurred liabilities;
2. Administrative expenses with a percentage (of benefit dollars) maximum;
3. Taxes;
4. A community support factor with a percentage maximum;
5. Mandatory statutory reserve requirements.

Any excess upon year-end accounting is credited to a Medicaid Reserve. Any deficit is recoverable from the Medicaid Reserve to the extent of the dollars available in the reserve. Any remaining deficit would be recovered from the Medicaid Reserve in subsequent years. A risk is obviously involved here.

A separate accounting is made to the State for interest on the Medicaid Reserve. A similar accounting is made for interest on unexpended prepaid charges which in the Plan judgment are in excess of the amount needed to promptly discharge Plan duties.

2018

PREPAID AGENT CONTRACT
FOR
PROVISION OF TITLE XIX BENEFITS

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PREPAID AGENT CONTRACT FOR PROVISION OF TITLE XIX BENEFITS

Date _____

Contractor: _____

Address: _____

ARTICLE I - PREAMBLEWHEREAS,

1. Title XIX of the Social Security Act, 79 STAT 343-353, herein-
after referred to as Title XIX, requires that care and services
provided under a State Plan to receive Federal Financial
Participation be provided in a manner consistent with proper and
efficient administration, simplicity, and in the best interests
of recipients under Statewide standards and utilizing such methods
as are necessary to assure that medical and/or remedial care and
services provided to recipients are high quality, and
2. The Laws of _____ (State) _____ (citation)
provide for medical assistance to recipients, and
3. It is desirable in the public interest that medical assistance
be provided in the most economical manner consistent with high
quality medical standards, and
4. Section(s) _____ of the _____ Law authorizes the
State Agency to contract with non-profit corporations authorized
by Law to operate non-profit hospital or medical service plans for
the purpose of providing services to _____ (if applicable
Eligible Persons, and _____ in your state)
5. The Department, hereinafter called "State Agency", is vested
with the power and the duty to supervise the administration of
Title XIX. In that capacity it requires certain accounting for
funds disbursed and other information as hereinafter provided, and
6. _____ and _____ (Plans)
hereinafter called Contractor are experienced in the functions
hereinafter undertaken by them in this contract.

including payments of and maintenance of relations with Providers, are equipped to promptly, efficiently and effectively perform their duties hereunder, and are willing to do so in furtherance of the public interest;

NOW, THEREFORE,

In consideration of the foregoing recitals and of the mutual promises contained herein,
The State of _____ by (_____)
pursuant to authority set forth in _____ (State) _____
(law citation) and _____ (Blue Cross Plan) _____,
a non-profit hospital service corporation, and
(Blue Shield) _____, a non-profit medical
service corporation, herein individually referred to as Blue Cross or Blue Shield, respectively, and collectively referred to as Contractor, each organized under the laws of the State of _____ hereby agree as follows:

- A. This contract shall begin on _____, and end on _____. It will automatically be renewed for successive periods of _____ unless the State Agency, Blue Cross or Blue Shield gives notice of intention to terminate the agreement at least _____ before the end of the current period. Any notice under this contract shall be sufficient if given to the State Agency, when mailed to it at _____ Office Building, _____; or, if given to Blue Cross, when mailed to it at _____; or, if given to Blue Shield, when mailed to it at _____.
- B. Blue Cross shall provide benefits as outlined in Article IV and, as to all functions and responsibilities of a Contractor under this Contract shall perform as to such benefits only. Similarly, Blue Shield shall provide benefits as outlined in _____ and shall perform as to such benefits only.
- C. This contract may be amended by written agreement duly executed by the State Agency and the Contractor. It is mutually understood and agreed that no alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and that no oral understandings or agreements are incorporated herein, and no alterations or variations of the terms hereof unless made in writing between the parties hereto shall be binding on any of the parties hereto. In addition, every such amendment shall specify the date its provisions shall be effective as agreed to by the State Agency and the Contractor.
- D. The enactment after date of signature of this contract by the parties or the effective date of this agreement, whichever occurs sooner, of any State or Federal statute or promulgation of implementing regulations thereunder shall

not apply to this contract unless made applicable by amendment to this contract pursuant to paragraph C above.

- E. This contract consists of eight major articles listed below. Addenda 1 through 11 are hereby attached to and made a part hereof.

- I Preamble
- II Definitions
- III Duties of the Parties
- IV Authorized Benefits and Exclusions
- V Administrative Provisions
- VI Charges
- VII General Provisions
- VIII Reimbursement for Additional Administrative Expenses
- IX Final Accounting

In Witness Whereof, the parties hereto have executed this contract the day and year first above written.

THE STATE OF _____

BY _____

(Title)

WITNESS

SEAL OF THE STATE OF _____ (if needed
under your
state's law)

2023

(Contractor)

BY _____

(Title) _____
(Title) _____

(Address) _____
(Address) _____

CERTIFICATES

I, _____, certify that I am the _____ of the corporation named as Contractor herein; that _____, who signed this contract on behalf of the Contractor, was then _____ of said corporation; that said contract was duly signed for and in behalf of said corporation by authority of its governing body, and is within the scope of its corporate powers.

(Signature) (CORPORATE SEAL)

I, _____, certify that I am the _____ of the corporation named as Contractor herein; that _____, who signed this contract on behalf of the Contractor, was then _____ of said corporation; that said contract was duly signed for and in behalf of said corporation by authority of its governing body, and is within the scope of its corporate powers.

(Signature) (CORPORATE SEAL)

ARTICLE II - DEFINITIONS

For the purpose of this contract the following definitions apply:

1. Secretary means the Secretary of Health, Education and Welfare of the United States of America.
2. Enrolled Recipient means a categorically needy person eligible for Medical Assistance in accordance with the State Medical Assistance Plan under Title XIX, and such other person within a class or classes of persons agreed to as eligible between the State Agency and the Contractor, who has been certified as such by the State Agency or a political subdivision of the State through the State Agency to the Contractor.
3. State Plan means the State's Medical Assistance Plan approved by the Secretary or his authorized delegate, The Commissioner, Medical Services Administration, for federal financial participation under Sections 1902, 1903, and 1904 of Title XIX of the Social Security Act (79 STAT 343-353).
4. Regulations means a Federal or State Agency statement of general applicability designed to implement or interpret law, policy or procedure.
5. Eligible Provider (except as otherwise provided in paragraph 11 below concerning non-medical public institutions and facilities) means an institution, facility, agency, person, partnership, corporation or association hereinafter defined in this paragraph as mutually certified by the State Agency and Contractor, and which accept as payment in full, the amounts paid as reasonable charges except as otherwise permitted under paragraph 15 below, unless payable on, and to the extent so payable on, the basis of reasonable costs.
 - a. Hospital - an institution providing 24-hour continuous nursing service to patients confined therein; which provides standard dietary, nursing, diagnostic, and therapeutic facilities; whose professional staff is composed only of physicians and surgeons, or of physicians and surgeons and doctors of dental surgery; and which is located in this state and approved as a hospital by the state's approving agency; or if located in another state is licensed or approved as a hospital by the appropriate standard setting authority in that state and is qualified to participate under Title XVIII of the Social Security Act or, is determined currently to meet the requirements of participation.
 - b. Skilled Nursing Home - a facility other than a facility operated (except incidentally) for the treatment of pulmonary tuberculosis or mental disorders, or a distinct part of a facility including such public facility which meets the following conditions:

- (1) The facility is constructed, equipped, maintained, and operated in compliance with all applicable State and local laws and regulations affecting the health and safety of the patients and their protection against the hazards of fire and other disasters, and there is a written, rehearsed disaster plan.
- (2) The administrator is qualified by training and experience for successful operation of a nursing home and has the necessary authority and responsibility for management of the facility.
- (3) The facility employs staff sufficient in number and qualifications to meet the requirements of the patients accepted for care or remaining in the facility for care.
- (4) Food is prepared and served under competent direction, at regular and appropriate times. Professional consultation is available to assure good nutritional standards and that the dietary needs of the patients are met.
- (5) Patient care is provided in accordance with written policies formulated with the advice of one or more physicians and one or more registered nurses.
- (6) Constructive care directed toward restoring and maintaining each patient at his best possible functional level is provided, including activities designed to encourage self-care and independence provided as a part of the patients' treatment program.
- (7) Patients in need of skilled nursing care are admitted to the facility only upon recommendation by a physician; the care of such patients is continuously under the supervision of a physician; and the facility maintains arrangements that assure that the services of a physician who can act in case of emergency are continuously available.
- (8) The facility provides 24-hour nursing services adequate in quality and amount to meet the needs of the patients who are admitted to, and remain in, the facility. The nursing service is directed by a registered nurse who is employed full time in the facility and is responsible for the total nursing service. At all times, there is a registered nurse, or a licensed practical nurse who is a graduate of a school of practical nursing, in charge of the nursing service, except that, in those instances in which a licensed practical nurse who is not a graduate of a school was successfully discharging the responsibilities of a charge nurse on July 1, 1967, such nurse may be employed in this capacity, only if she has completed training or examination satisfactory to the appropriate State licensing authority.

- (9) All drugs and medications are prescribed, handled, stored and administered in accordance with accepted professional practices, state, and federal regulations.
 - (10) An individual clinical record is maintained for each patient covering his medical, nursing, and related care in accordance with accepted professional standards for accreditation.
 - (11) Effective arrangements are maintained through which services required by the patients but not regularly provided within the facility, can be obtained promptly when needed. This includes laboratory, X-ray, and other diagnostic services, and regular and emergency dental care. It includes, also, provisions for recognition of need for social services and for prompt reporting of such need to the local welfare department or other appropriate source.
 - (12) The facility is licensed or formally approved as a nursing home by an officially designated State standard-setting authority.
- c. Physician - a person licensed to practice medicine and surgery in the state where services are provided and includes graduates of osteopathic colleges holding an unlimited license to practice medicine and surgery.
 - d. Doctor of Dental Surgery - a person licensed to practice dentistry or dental surgery in the state where services are provided.
 - e. Home Health Care Agency - a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:
 - (1) It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services. A public or voluntary non-profit health agency may qualify by: (a) furnishing both skilled nursing and at least one other therapeutic service directly to patients, or (b) furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary non-profit agency to furnish the services which it does not provide directly. A proprietary agency can qualify only by providing directly both skilled nursing service and at least one other therapeutic service.

- (2) It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered nurse) to govern the services, and provides for supervision of such services by a physician or a registered nurse.
 - (3) It maintains clinical records on all patients.
 - (4) It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations).
 - (5) It meets other conditions found by the Secretary of Health, Education, and Welfare to be necessary for health and safety. A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State Law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the medical assistance program.
- f. Registered Pharmacy - a drug store with a permit from and registered by the State Board of Pharmacy; or a drug store in another state registered, licensed, or approved as such by the appropriate standard-setting authority in that state.
- 6. Illness means a bodily disorder, bodily injury, disease, or mental disease. All illnesses existing simultaneously which are due to the same or related causes, shall be deemed to be the same period of illness. Successive illnesses occurring within _____ days, which are due to the same or related causes, shall also be deemed to be a part of the same "period of illness." Successive periods of illness shall be separated by more than _____ days.
 - 7. Day, with respect to the exclusion of subparagraph B 1 of Article IV (_____ days per period of illness in excess of those provided by the State Plan) means:
 - a. each midnight hospital bed occupancy while under registration in the hospital as an inpatient.
 - b. each hospital bed occupancy where admission and discharge occur on the same calendar day while under registration in the hospital as an inpatient.
 - 8. Semiprivate Room means a two-bed, three-bed or four-bed accommodation.
 - 9. Mental Disease means any condition classified as a neurosis, psycho-neurosis, psychopathy, or psychosis.
 - 10. Prescription means a written order or an oral order by a licensed physician or dentist for a product or service to be given a patient.

11. Non-Medical Public Institution means a hospital which has not been so approved as a hospital by, or a nursing home which has not been licensed by, the State Health Agency and which is either a unit of, or under the administrative control of a State, Federal or local government.
12. Supplement D means the Handbook of Public Assistance, Supplement D published by the U.S. Department of Health, Education and Welfare, Welfare Administration as amended by numbered Handbook Transmittals by which the State Agency is guided in the development operation of the State Plan.
13. State Agency means the single State Agency designated or established by the Governor of the state under the provision of Section 1902 a (5) Title XIX of the Social Security Act, to administer the State Medical Assistance Plan.
14. Reasonable Cost means the reimbursable portion of allowable costs for inpatient hospital services (or other services by Eligible Providers as may be provided under the State Plan) for Enrolled Recipients determined in accordance with Addenda 2 or Article V, which are designed to take into account that all allowable costs with respect to an Enrolled Recipient shall be borne by the Enrolled Recipient part of the Enrolled Recipient's allowable cost of care shall be attributed to the cost of another patient's care or to another program. "Allowable costs" for purposes of this paragraph 14 shall mean all necessary and proper expenses of an institution in the production of patient services, the elements of which shall be those permitted and applicable under Principles of Reimbursement for Provider Costs, published by the Social Security Administration.
15. Reasonable Charges means the method of payment of the Contractor for services under the State Plan to Enrolled Recipients which shall have evidence of agreement by Eligible Providers that payments will be accepted, as payment in full, except that prior to January 1, 1971, with respect to care furnished in a skilled nursing home, to the extent that the State has contrary existing arrangements with Eligible Providers and the State Agency justifies such arrangements to the Secretary on the basis that it is not otherwise able to enlist sufficient Eligible Providers to insure adequate care for all Enrolled Recipients. The State Agency may by amendment to Article III pursuant to Paragraph C of Article I provide for assistance by Contractor in establishing fee structures for the various Eligible Providers designed to enlist participation of sufficient Eligible Providers so that Enrolled Recipients can receive medical care and services under the State Plan at least to the extent available to the general public.

For medical care institutions other than hospitals (and hospitals to the extent payable on a charge basis for outpatient hospital services) the fee structure will focus on a reasonable cost basis determined as the State Plan provides either (a) according to commonly used accounting methods on a ratio of costs to charges basis or (b) under methods for comparable institutions used under Part A of Title XVIII of the Social Security Act and implementing regulations pursuant to Title XVIII.

16. Retroactive Adjustment - the procedure and the payment of funds to a hospital after an accounting period has revealed that the cost of care received was more or less than the amount paid by the Contractor and State Agency. If the single State Agency is unable to provide for payment of retroactive adjustments, an additional allowance of _____ % of charges in lieu of a retroactive adjustment shall be made.
17. Inpatient - a person registered and given a "register number" as such by a hospital or skilled nursing home for bed occupancy in a hospital or skilled nursing home.
18. Outpatient - a person registered as such by a hospital for outpatient services, but not as an inpatient for bed occupancy.
19. Current Information - Information regarding a State Plan, Policy, Regulation, Handbook Transmittal, State Letter, Report, Instruction, or Eligible Recipient-the effective date of which encompasses an interval of time no longer than seven days from receipt by the Contractor or State Agency.
20. Medical Care Administration - this term is used to refer to the combined organization, staff management, and evaluation of personal health maintenance services with practitioners, institutions, and agencies through which medical care and services of a personal nature are planned for, financed, provided, and delivered to an individual within or close to this community environment. Among the necessary control methods are:
 - a. The Management Audit: A comprehensive and constructive examination of a Medical Program's organizational structure or its components, such as a division or department; its plans and policies; its quality, quantity, and financial controls; its methods of operation; and its use of human and physical resources.
 - b. The Medical Audit: A review, evaluation, and analysis of the elements of medical care and services, and their available adjunct statistics which facilitates the extension and improvement of a medical care program.
 - c. The Fiscal Audit: A review and evaluation as to adequacy and reliability of (1) the records and procedures of the accounting system of a program or an agency, (2) the operation of the accounting system, and (3) the preparation and interpretation of fiscal reports.
21. Comprehensive Medical Care Program - within the parameters of providing public Medical Assistance to pay for medical care and services, this term is defined as including:

- a. Personal health maintenance.
- b. The early detection of disease and injury.
- c. Proper diagnosis.
- d. Appropriate treatment and therapy.
- e. Regular follow-up, particularly in long-term cases. to enable competent medical supervision to secure allied and supportive services at the time needed.
- f. Timely evaluation of the patient's potential for specific rehabilitation, home care, or nursing home services - with appropriate referral.

22. Continual Year means the 12 calendar months commencing on the effective date hereof and each yearly period thereafter.

ARTICLE III - DUTIES OF THE PARTIES

A. CONTRACTOR DUTIES

Contractor shall perform the services listed hereinafter incident to the provision of benefits under Article IV with respect to Persons under the State Plan becoming Enrolled Recipients under this contract as specifically designated herein or, if not so designated, in the manner Contractor performs for its regular group accounts. Any additional duties agreed to by the parties shall be at additional cost.

1. Advise and assist the State Agency as appropriate in carrying out the provisions of the State Plan.
2. Issue identification cards to the State Agency, as appropriate, for delivery to each Enrolled Recipient.
3. Install and implement appropriate mechanical, or electronic data processing procedures to:
 - a. Audit claims in accordance with procedures required in Article V, Addendum 5.
 - b. Reject all claims not payable under the State Plan and applicable regulations, and
 - c. Notify the provider submitting the claims of their rejection and of the reason therefor.
4.
 - a. Within agreed-to period (not to exceed 30 days) of receipt of proper evidence establishing the validity of claims, invoices, and statements, prepare checks or drafts for payment of approved items and forward such checks or drafts to providers.
 - b. With respect to Eligible Providers which have furnished Enrolled Recipients benefits, payment for which is to be made on a reasonable cost basis, Contractor shall as provided in this subparagraph "make provisions for payments".
 - (1) On an interim basis, not less often than once each calendar month, in an amount which, in the judgment of Contractor, will approximate the reasonable cost of such services, and
 - (2) On a final audited annual basis for the reasonable cost of such services.
5. Develop and maintain procedures relating to utilization control practices as specified in Article V, Addendum 3.

6. Participate in all appeal or fair hearings where issues involve the Contractor as determined by the State Agency;
7. Notify the State Agency of the date of death of Enrolled Recipient insofar as this information is available to the Contractor;
8. Develop and revise as necessary a manual of procedures for Eligible Providers;
9. Develop and revise as necessary a manual governing Contractor's operation hereunder;
10. Develop and implement procedures to enable Eligible Providers to utilize other sources of payment available to Enrolled Recipients to the extent permitted under the State Plan;
11. Maintain such records and afford such access thereto as the State Agency finds necessary as provided in paragraph C of Article V;
12. Furnish to the State Agency such information and reports in the content and format outlined in various Addenda to Article V;
13. Contractor shall in accordance with regulations make audits of records of Eligible Providers payable on an actual or apportioned cost basis through such mechanisms as may be mutually agreed.
14. In the event that the State Agency desires Contractor to perform other than or in addition to the above duties, mutual agreement between the parties hereto with respect to such duties and to the additional cost thereof, perform any one or more of the following duties:

ILLUSTRATIVE: THE PLAN SHOULD ASSURE THAT ALL ADDED DUTIES ARE INCLUDED IF NOT ACCOUNTED FOR IN THE RATE:

- a. Upon prior approval of the State Agency draft informational and instructional materials, subject to approval of form and content by the State Agency for purposes of interpreting to Eligible Providers the nature and scope of the program and policies, procedures, and requirements thereunder, and arrange for printing of such materials and carry out such further interpretive programs with providers as may be necessary;
- b. Upon prior approval of the State Agency distribute informational and instructional materials to all possible Eligible Providers together with notification to such providers of their right to participate in the program subject to policies and procedures outlined in such informational materials, and request such providers to inform the Contractor of their desire to participate;
- c. Upon prior approval of the State Agency where appropriate, develop providers claim forms subject to approval of format and content by the State Agency. Upon approval, Contractor will arrange for printing or procurement of such forms;
- d. Establish such procedures as the State Agency may approve for resolution of disputes between Eligible Providers and Contractor and between Contractor and Enrolled Recipients;

- e. Assist either Eligible Providers, the medical assistance unit of the single State Agency or both in the development of procedures relating to utilization control practices as specified in Article V, Addendum 3 and assist in the application of such safeguards as may be further specified by the State Agency in writing against unnecessary utilization of care and services by Enrolled Recipients, Eligible Providers (following consultation with Contractor) and others;
- f. Contractor shall in accordance with written request by the Medical Assistance Unit of the single State Agency make medical reviews of records of Eligible Providers whether participating under Title XVIII or not.
- g. Prepare and submit to the State Agency invoices of Contractor with appropriate documentation to cover the payments described in the foregoing subparagraph 5 pursuant to Section D of Article and applicable Addenda;
- h. Assist in the application of safeguards, as specified by the State Agency related to fraud or abuse by beneficiaries, providers, and others;
- i. In cases of suspected fraud or abuse, or other overpayment, or upon written request from the State Agency, Contractor shall withhold payments to the particular Eligible Provider or other payee, in an amount sufficient to safeguard the funds of the State, and upon written request shall assist the State Agency to obtain repayment for payments inappropriately made for persons not Enrolled Recipients or otherwise, but shall not be required legal action to recover such funds;
- j.
 - 1. In conjunction with the State Agency provide assistance in establishing liaison and coordination with providers, and with other interested groups, committees, and similar bodies, and,
 - 2. Establish such procedures as the State Agency may approve for resolution of disputes between Eligible Providers and Contractor and between Contractor and Enrolled Recipients.
- k. Prepare and distribute informational and instructional materials for purposes of interpreting to Enrolled Recipients the nature and scope of the program and policies, procedures, and requirements thereunder.
- l. _____
- m. _____

15. Contractor may subcontract for some of its services provided for herein to be performed by qualified organization or persons.

B. STATE AGENCY DUTIES

The State Agency must provide the Contractor with an adequate administrative foundation on which to carry on his duties. To this end the State Agency shall, in addition to the payment of charges as specified in Article VI:

1. Establish and certify the eligibility of Enrolled Recipients entitled to care under the State's Medical Assistance Program pursuant to Addendum 1 of Article V;
2. Provide the Contractor on a continuing basis by mechanical or electronic means complete, current, and accurate certification lists as to the eligibility status of Enrolled Recipients entitled to medical care and services pursuant to Addenda 1 and 11 of Article V;
3. Advise Enrolled Recipients of the necessity of indentifying themselves to the Eligible Providers;
4. Provide the Contractor with copies of all current administrative regulations under which the State Plan is to be operated;
5. Provide the Contractor with current information regarding Eligible Providers whose services under the program have been lawfully terminated or suspended and no longer meet the definition of Eligible Providers set forth in Article II at subparagraph 5;
6. Cooperate with the Contractor in the implementation and administration of designated responsibilities under this contract;
7. Furnish Contractor by letter the names of the individuals, together with the scope of authority, authorized to act for the State Agency.
8. Pay the charges provided for pursuant to Article VI and any specially negotiated costs for duties enumerated in subparagraph A 14 of Article III.
9. Refrain from interfering with Enrolled Recipients' freedom of choice as between Eligible Providers.

ILLUSTRATIVEARTICLE IV - AUTHORIZED BENEFITS AND EXCLUSIONS

For illustrative purposes this Article describes the scope of benefits and exclusions which may be included in a State Plan. Benefits described in subparagraphs A 1 through A 5 are required as of July 1, 1967. Further additions to this section should be developed from each State's Plan. Benefits provided should take the form provided below and be available from any qualified provider at the free choice of the recipient.

A. AUTHORIZED BENEFITS

The Contractor shall pay on behalf of an Enrolled Recipient reasonable costs or reasonable charges as applicable for Medical Care and services to Enrolled Recipients for the following benefits, subject to the exclusions and limitations hereinafter set forth in paragraph B.

1. Inpatient Hospital Care means those items and services ordinarily furnished by the hospital for the care and treatment of inpatients, which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with illness other than tuberculosis or mental diseases and which is licensed or formally approved as a hospital by an officially designated State standard-setting authority; and is qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation; and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Title XIX.

A Hospital shall be entitled to payment, on the basis set forth at Article V Addendum 2, for such number of days per period of illness as may be provided under the State Plan for inpatient hospital care furnished Enrolled Recipients when the admission to the hospital and period of hospitalization thereafter are medically necessary for diagnosis or treatment (or both) of an illness and when such care furnished is prescribed by a physician or doctor of dental surgery as necessary for the diagnosis or treatment of the condition for which hospitalization is required.

Inpatient hospital care shall consist of the following services provided by the hospital or by contractual arrangement made by or through the hospital:

- a. Bed and board, including special dietary service, in a semi-private room to the extent available - unless a private room is medically necessary;
- b. Professional services furnished through or by the hospital including physician, general nursing, physical and occupational therapy, services by voluntary or paid hospital employees, or by an intern, resident, or other physician in training in the hospital;

c. Laboratory services, therapeutic or diagnostic services involving the use of x-ray, radium, or radioactive isotopes, use of operating room, recovery room and emergency room drugs, medical supplies, equipment and appliances, as related to care and treatment in the hospital.

2. Outpatient Services - Outpatient Hospital Services means those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution licensed or formally approved as a hospital by an officially designated State standard-setting authority; and is qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

A hospital shall be entitled to payment on the basis of Article V Addendum 2 for outpatient services provided through the hospital, when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment, or both, of the condition for which outpatient services are required.

3. Skilled Nursing Home Services - this term is defined as those items and services furnished by a skilled nursing home maintained primarily for the care and treatment of inpatients with disorders other than tuberculosis or mental diseases which are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law.

A skilled nursing home shall be entitled to payment pursuant to Article V Addendum 2 for inpatient care and services to Enrolled Recipients when the admission to the skilled nursing home and period of care thereafter are necessary for the diagnosis or treatment, or both, of the condition for which nursing home care is required, and when the services provided are prescribed by and performed under the general direction of a physician.

Skilled nursing home care shall consist of those items and services ordinarily provided by a nursing home for the care and treatment of inpatients, and includes the following:

- a. Nursing care provided as defined in Article II, Paragraph 8.
- b. Other medical services related to such nursing care including services of physicians and therapists who have a position in management of the home or who are employed by the home;
- c. Bed and board including special dietary services in a semi-private room, or if medically necessary in a private room, in connection with provision of such nursing care and use of equipment which is owned by the home and ordinarily provided in the care and treatment of patients.

4. Laboratory and X-ray Services means professional and technical laboratory and radiological services ordered by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law, and provided to a patient by, or under the direction of, a physician or licensed practitioner, in an office or similar facility other than a hospital outpatient department or clinic, and provided to a patient by a laboratory that is qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.
5. Physician's Services - the term "physician's services" is defined as those services provided, within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

A physician shall be entitled to payment, pursuant to Article V Addendum 2 for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within the scope of practice of his profession, as defined by State law, when provided to Enrolled Recipients, and when such services are medically necessary in relation to the condition for which care is required.

6. Home Health Care Services - An organized Home Health Care agency or an official agency shall be entitled to payment, pursuant to Article V Addendum 2 for home health care services provided through such agency to certified eligible persons who are under the care of a physician. All services furnished by a Home Health Care Agency, whether provided directly by the Home Health Agency or under arrangements with others, must be furnished by qualified personnel. The following items and services when provided by the Home Health Care Agency, or by others under arrangements with the Home Health Care Agency, are covered under Title XIX. Benefit must be provided on and after July 1, 1970 if skilled nursing home services are a benefit.
 - a. Part-time or Intermittent Nursing Care - Nursing care is professional nursing service provided by a registered nurse, preferably a qualified public health nurse, in accordance with a physician's orders, or the practical nursing service provided by a licensed practical or licensed vocational nurse working under the supervision of a registered nurse. Part-time or intermittent care is usually service for a few hours a day several times a week. Occasionally, service for a full day may be provided for a short period when, because of unusual circumstances, neither the alternative of part-time nor hospitalization is feasible.
 - b.. Physical, Occupational, and Speech Therapy.
 - (1) Physical Therapy - Physical therapy is service provided in accordance with a physician's orders by or under the supervision of a qualified physical therapist. A qualified physical therapist is an individual who is licensed or registered by the State when licensure laws are applicable.
 - (2) Speech Therapy - Speech Therapy, that is, service in speech pathology or audiology, is service provided in accordance

with a physician's orders and furnished by or under the supervision of a qualified speech therapist. A qualified Speech Therapist is an individual who is certified by the American Speech and Hearing Association, or who has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for such certification. (The term "speech therapist" includes a speech pathologist.)

- (3) Occupational Therapy - Occupational therapy is service given in accordance with a physician's orders and by or under the supervision of a qualified occupational therapist. A qualified Occupational Therapist is an individual who is registered by the American Occupational Therapy Association or is a graduate of a program in such therapy approved by the Council on Medical Education of the American Medical Association, and is engaged in the required supervised clinical experience period prerequisite to the registration by the American Occupational Therapy Association.

c. Medical Social Services- These services must be under the direction of a physician and must be given by or under the direct supervision of a qualified medical or psychiatric social worker. A qualified medical or psychiatric social worker is an individual who is a graduate of a school of social work accredited by the Council on Social Work Education, and who has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

7. Pharmaceutical Services - a registered pharmacy shall be entitled to payment, pursuant to Article V Addendum 2, for legend drugs, (which by law require a prescription) provided to Enrolled Recipients which are prescribed by a physician or a doctor of dental surgery, as medically necessary for the diagnosis or treatment, or both, of the condition for which such drugs are required. Drugs shall be provided only in the kind and amount specified by the prescription. Refills of prescriptions may be provided if they are specified by the prescription, except that no refills shall be provided when the prescription so indicates.
8. Nurses Services - a registered nurse or a licensed practical nurse shall be entitled to payment pursuant to Article V Addendum 2 for services provided within the scope of practice of their profession, as defined by State law, when provided to Enrolled Recipients, under the general direction of a physician, to the Enrolled Recipient in his own home, or in a hospital or nursing home when the Enrolled Recipient requires individual and intermittent, part-time or continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or nursing home.
9. Podiatry Services - A podiatrist shall be entitled to payment pursuant to Article V Addendum 2 for services provided within the scope of practice of his profession, as defined by State law, when provided to Enrolled Recipients, and when such services are necessary in relation to the condition for which care is required.

Such services shall include diagnosis or mechanical, medical or surgical treatment, or treatment by use of drugs of the feet, but shall not include major surgery or the use of a general anesthetic. Diagnosis of treatment shall include no portion of the body above the feet except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg insofar as they shall be involved in conditions of the feet.

10. Optometry Services - An optometrist shall be entitled to payment pursuant to Article V Addendum 2 for services provided within the scope of practice of his profession, as defined by State law, when provided to Enrolled Recipients, and when such services are necessary in relation to the condition for which care is required.

Such services shall include determination of visual efficiency, measurement of the powers or defects of vision, furnishing, using or employment of any means or device designed or calculated to aid in the selection or fitting of eyeglasses, adaptation of lenses or prisms and mechanical therapy or exercise for ocular muscular imbalance to aid the vision of an Enrolled Recipient.

11. Eyeglasses

A Physician skilled in the diseases of the eye, and optometrist or dispensing optician within the scope of practice of his profession, as defined by State law, shall be entitled to payment pursuant to Article V Addendum 2 for eyeglasses when prescribed by a physician skilled in the diseases of the eye or an optometrist.

Eyeglasses are defined as lenses and frames prescribed to aid or improve vision.

Services of a dispensing optician shall be limited to the taking of necessary facial measurements, and the processing, fitting and adjusting of mountings, frames, lenses and kindred products in the filling of prescriptions of a physician skilled in the diseases of the eye or an optometrist for ophthalmic lenses. Duplications, replacements or reproductions not requiring optometric service may be provided without a prescription.

12. Medical Supplies and Equipment, Including Rental of Durable Equipment

Payment shall be made, pursuant to Article V Addendum 2 for medical supplies and equipment, including rental of durable equipment such as iron lungs, oxygen equipment, hospital beds and wheelchairs, as ordered or prescribed by the physician as required for the care of the patient, and as provided to Enrolled Recipients.

Medical supplies and equipment include items such as dressings, fever thermometers, hot water bottles, bedpans, crutches, hearing aids, trusses, surgical garments, supplies for administration of insulin, durable equipment, etc.

13. Prosthetic Devices - Payment shall be made, pursuant to Article V, Addendum 2 for prosthetic devices for Enrolled Recipients, including replacement, corrective or supportive devices prescribed by a physician for the purpose of artificially replacing a missing portion of the body, or to prevent or correct physical deformity or malfunction or to support a weak or deformed portion of the body.

14. Other Screening, Diagnostic, Preventive, Rehabilitative, and other Medical Services

Payment shall be made for other screening, diagnostic, preventive, rehabilitative and medical services pursuant to Article V, Addendum 2 for Enrolled Recipients.

Other diagnostic services include any medical procedure or supplies recommended for an Enrolled Recipient by his physician or dentist as necessary to enable him to identify the existence, nature, or extent of illness, injury or other health deviation in the patient.

Screening services may include multiphasic screening services where appropriate equipment is available and use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify suspects for more definitive studies.

Preventive services include those provided by a physician to prevent illness, disease, disability and other health deviations or their progressions, or to prolong life and promote physical and mental health and efficiency.

Rehabilitative services include any medical items or services prescribed for an Enrolled Recipient by his physician for the purpose of maximal reduction of physical or mental disability and restoration of the patient to his best possible functional level.

Other medical services include any medical items, procedures or services prescribed by physician as necessary to enable him to treat illness, injury, disability and other health deviation of the Enrolled Recipient.

15. Transportation to Obtain Medical Care - Operators of an ambulance service shall be entitled to payment pursuant to Article V, Addendum 2 for ambulance service when the vehicle in which service is provided is an authorized emergency vehicle and when such services are necessary to secure medical examination or treatment, or both.

Guidelines for determining medical necessity of such services shall be mutually agreed upon by the parties hereto. Ambulance services, transportation by automobiles, and other transportation services include cost of outside meals for the Enrolled Recipient enroute to and returning from a medical facility, payable to the operator of an ambulance service.

16. Deductible and Coinsurance Portions of Health Care Benefits Paid Under Title XIX of the Social Security Act

Payment shall be made, pursuant to Article V, Addendum 2 for deductible and coinsurance portions of bills for health care benefits paid in part under Title XVIII of the Social Security Act.

B. EXCLUSIONS AND LIMITATIONS

Again it must be noted that the following items are for illustrative purposes only.

1. The maximum combined liability for payment for services furnished an Enrolled Recipient for (1) the reasonable cost of inpatient care in a hospital or skilled nursing home, (2) reasonable charges for professional services performed by a physician in a hospital or skilled nursing home, and (3) reasonable charges for professional services performed by a doctor of dental surgery in a hospital or skilled nursing home, shall be for such number of days per period of illness as provided under the State Plan. That number of days is _____.
2. Payment shall not be made for any medical care benefits for an Enrolled Recipient who is under 65 years of age and who is confined in an institution for tuberculosis or mental diseases.
3. Payment shall not be made for medical care and services furnished Enrolled Recipients confined in a non-medical institution which is either a unit of, or under the administrative control of, a federal, state or local government. This exclusion shall not apply to payment for services furnished by a hospital approved by, or a skilled nursing home licensed by, the State Health Agency if the billing form bears a certification that the Enrolled Recipient was: (1) admitted to a medical institution on recommendation of a physician or a dentist because of illness, injury or other defect, (2) that there is planned for the Enrolled Recipient continuing medical, psychiatric, or dental treatment, including nursing care, directed toward improvement of health (or for whom palliative medical measures are required even though improvement in health or recovery may not be expected) and (3) is receiving professional medical treatment.
4. Payments shall be made by the Contractor only in behalf of individuals who have been certified as Enrolled Recipients to the Contractor by the State Agency, and only for medical care and services received by such Enrolled Recipients during the certified period of eligibility pursuant to the provisions of Article V Addendum 1 "Certifications of Eligibility."
5. Payments shall be made only for, and to the extent that, benefits are specified by this part of the contract and as it may be amended from time to time in accordance with paragraph D of Article I.
6. Payment shall be reduced to the extent that part of any services available under the State Plan which are payable through insurance, third party liability, or any federal, state, county, municipal or private benefit systems to which the Enrolled Recipient may otherwise be entitled subject to subparagraph 11.
7. Payments shall be reduced to the extent that part of any benefits provided under the State Plan which are covered by any health, accident, or other insurance policy or by any private or other governmental benefit systems, and in determining coverage, no exclusion of the insurance policy or benefit system with respect

to benefits otherwise payable under the State Plan shall be taken into account, (Eligibility under the State Plan does not exist except for that portion of benefits payable to Eligible Providers in excess of other health, accident, or other insurance coverage, or private or governmental benefit system coverage, regardless of policy or benefit system exclusions pertaining to availability of benefits under the State Plan.)

8. In accordance with Article V Addenda 1 and 11, the Contractor will be provided with current information on the certification of eligibility from the State Agency regarding health, accident, or other insurance, or governmental or private benefit systems, through which the Enrolled Recipient may be entitled to payments for medical care and services provided under the State Plan.
9. The Contractor shall require Eligible Providers to inquire into all such policies or benefits, including the circumstances giving rise to the need for benefits, with a view to determining availability of Workmen's Compensation coverage which may be available to the beneficiary at the time the need for medical services arises, and to report on the claim to Contractor for services rendered, the possible availability of such benefits.
10. When the Enrolled Recipient has health, accident, or other insurance policies, or when he is under a private or a governmental benefit system, or both, the Contractor shall withhold payment of the claim until such time as the amount of benefits available for the medical care or services provided is determined and reported to the Contractor by the Eligible Provider. In making payment to the Eligible Providers such benefits shall be deducted from reasonable costs or charges as the case may be.
11. No claim shall be paid except as the Eligible Provider certifies that no supplemental charges beyond those established by Article V Addendum 2 and billed as total charges to Contractor, have been or will be billed to the beneficiary for services provided under the State Plan.
12. When a claim is received from an Eligible Provider in another state, for an Enrolled Recipient, the Contractor shall notify the State Agency which made such certification, and shall withhold payment of the claim until such time as the State Agency advises as to current residence of the beneficiary. Payment of such claims shall not be made if the State Agency notifies the Contractor that the Enrolled Recipient no longer has residence in this state except as may be permitted by the State Plan.
13. Payment shall not be made for any services which are or can be paid for as post-hospital home health care services under Part A of Title XVIII of the Social Security Act, or for any services which are paid for as medical or health services or home health services under Part B of Title XVIII of the Social Security Act, or (to the extent provided under the State Plan) which could have been paid had the individual enrolled and paid the monthly premium. This clause is not binding until after December 31, 1969.

14. Private room facilities shall not be considered "medically necessary" except when on the basis of medical opinion critical or contagious illness exists, or when the Enrolled Recipient's condition results in undue disturbance to other patients, or the need for care is emergent and lower cost facilities are not immediately available. When private room facilities are used, the Enrolled Recipient shall be transferred to lower cost facilities as soon as medically feasible.

ARTICLE V - ADMINISTRATIVE PROVISIONS

A. GENERAL

1. The provisions of this contract shall not alter the right of Enrolled Recipients to the free choice of physician, dentist, pharmacy, hospital, skilled nursing home or other provider of care insofar as the provider of care meets the appropriate definitions of Eligible Providers of care. No provider of care shall be required to operate exclusively under this Contract. The legal responsibility of physician, dentist or hospital to patients and all rights and duties of providers arising from relationships with patients shall not be affected hereby.
2. Contractor agrees to employ as appropriate the services of medical, dental, or pharmaceutical consultants duly licensed in these professions and medical care administration consultants, who shall to the extent administratively and legally appropriate, perform the duties described in Addendum 5 in all fields in which Contractor pays for medical care.

B. REIMBURSEMENT PRINCIPLES

Contractor's payment for benefits to Eligible Providers shall be in accordance with the provisions and procedures enumerated in Addenda 1 through 5 of Article V, concerning eligibility, basis of payment, utilization review and certification, claim form and audit of claim forms. Benefits authorized are limited to those described in Article IV of this Contract.

C. BOOKS AND RECORDS

The Contractor shall maintain books, records, documents and other evidence pertaining to this Contract to the extent and in such detail as shall properly reflect performance hereunder.

The Contractor agrees to preserve and make available such records for a period of six years (or if shorter, such period as may be permitted by the laws of (State) and the U.S.) from the date of service rendered. Records involving matters in litigation shall be kept for one year following the termination of litigation if the litigation has not terminated within such period.

The Contractor agrees to make such records available to any representative of the State Agency, the Secretary, and/or the Comptroller General of the United States at Contractor's offices at all reasonable times within the required period of retention, for inspection, audit, or reproduction.

D. BOND

The Contractor shall procure and thereafter maintain a fidelity bond in an amount to be decided upon by the State Agency but not in excess of \$50,000.

E. FAIR EMPLOYMENT PRACTICES

The Contractor agrees to be bound by, and to comply with applicable State and Federal laws and regulations concerning fair employment practices and such regulations may be attached hereto and thereby made a part hereof.

ARTICLE V, ADDENDUM 1 - STATE AGENCY CERTIFICATION OF ELIGIBILITY

A. GENERAL

The State Agency shall cause certification of Enrolled Recipients for care under the State Plan to be made by the various (state, county, city, etc. as applicable in the State) welfare agencies to Contractor. Such certification shall be delivered to Contractor within seven days after the determination of eligibility is made. Such eligibility certification shall be accomplished by mechanical or electronic means adaptable to data processing such as punch card, tape, disk.

- B. The single State Agency shall distribute appropriate eligibility cards or other suitable document to Enrolled Recipients indicating benefits authorized.

C. ELIGIBILITY VERIFICATIONS BY PROVIDERS

1. The single State Agency shall advise Enrolled Recipients concerning the medical care and services to which they are entitled, and shall advise Enrolled Recipients of the necessity for identifying themselves as such for medical assistance at the time of their visit to any Eligible Provider to whom the Contractor is required to make payment for allowable benefits under Article IV. Where a claim submitted by such Eligible Provider to the Contractor is "complete" in accordance with Addendum 4 and where it appears on the face of the claim (and related documents available to the Contractor at the time) that the provider submitting the claim exercised reasonable care and precaution in establishing that an individual seeking care was an Enrolled Recipient and, has furnished authorized care, and if the Contractor has no reason to believe otherwise from information available at the time, then the Contractor may pay the claim without recourse by the State Agency against the Contractor.
2. Claims which are not "complete" in accordance with Addendum 4 shall not be paid by Contractor unless otherwise authorized by the State Agency and agreed to by the Contractor; and, if the Contractor received knowledge that an individual described in paragraph 1 above is receiving care from a named Eligible Provider and that such individual is not eligible for medical care and services at State expense, then Contractor will not be eligible to receive reimbursement from the State Agency for any payment made for care provided by such provider to that individual subsequent to midnight of the first day following the date of receipt of that knowledge, which is not a Saturday, Sunday, or a legal holiday.
3. If the Contractor receives reliable information in writing that the Eligible Provider has received knowledge from other than the Contractor that an individual described in paragraph 1 above receiving care from him or either (a) was never eligible for care, (b) was eligible for care but eligibility therefore had been terminated, or (c) would cease to be eligible for care on a certain date, the Contractor will not be eligible to receive payment from the State Agency for care furnished by such Eligible Provider after midnight of the date of receipt by such provider of knowledge of the existence of either situation covered in (a) or (b) of this proviso or after midnight of the "certain date" mentioned in (c) of this proviso.

4. Where payment has been made by the Contractor on a claim that covers Authorized Benefits in accordance with Article IV is "complete" in accordance with Addendum 4 of Article V for care rendered to an individual who was not an Enrolled Recipient, and where there is evidence that the Eligible Provider receiving payment did not exercise reasonable care and precaution in identifying that individual, the Contractor will question the provider as to the means used to identify the individual and benefits authorized and shall furnish information received to the State Agency.

ARTICLE V, ADDENDUM 2 - BASIS FOR PAYMENT TO PROVIDERSA. INPATIENT HOSPITAL CARE AND OUTPATIENT CARE
PROVIDED THROUGH A HOSPITAL

1. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of medical assistance,
 - a. For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the State agency will apply the same standards, cost reporting period, cost reimbursement principles and method of cost apportionment currently used in computing reimbursement to such hospital under Title XVIII, except for adaptations permitted in the chapter D-5360, of the Handbook of Public Assistance Administration, Supplement D.
 - b. For each hospital not participating in the Title XVIII program, the State agency will apply the standards and principles described in Sections 1-1 through 1-12 of "Principles of Reimbursement for Provider Costs" (HIM-5 Revised) and the related regulation sections 405.415 - 405.429 issued by the Social Security Administration, except for adaptations permitted in this chapter, D-5360, and either (1) of the acceptable cost apportionment methods described in section 2-2 (regulation section 405.425 of HIM-5 Revised) or (2) the "Gross RCC Method" of cost apportionment (described in D-5364.2, item b).

Allowance in Lieu of Retroactive Payments - In the event that retroactive adjustments are not permitted under State law, Contractor shall adjust current payments in the light of anticipated current reasonable costs. Contractor will, if feasible, use a percentage adjustment of a hospital's reported costs to bring such costs in line with current levels as nearly as they can be estimated in advance. When and if State Agency's payments exceed the actual level of reasonable costs, the hospital shall be required by Contractor to make the necessary adjustments.

- c. Payment procedures of Reasonable Cost determination for Title XIX patients shall comply with the Act's requirement for "simplicity." In this connection when gross RCC is applicable the Contractor shall divide the "total allowable annual cost" for a given hospital by the "total annual billings or charges" to arrive at a historical percentage figure of cost to charges. To this will be added quarterly, a percentage figure representing the difference between the current cost index of the State's hospitals - by type of hospital and the historical cost index. Each patient's bill of "charges" will then be reduced or otherwise adjusted by the sum of the two percentages to pay only the "current reasonable cost" of the individual patient's care. This Gross Ratio of annual Cost to annual Charges (Gross R.C.C.) applied to individual patient billing requires no change in a hospital's cost accounting system. Hospitals using the "Gross RCC Method" will use a report form containing information prescribed by the Medical Services Administration, S.R.S. D/H.E.W.

2. Total allowable items of cost will be the same items of cost as are included in the Social Security Administration's Manual "Principles of Reimbursement for Provider Costs."
3. If a hospital does not participate in Title XVIII, an independent audit of a hospital's accounts will be reviewed or accounts will be audited pursuant to subparagraph A 13 of Article III for percentage determinations and where gross RCC method of 1b above is used, a copy of the hospital's audit shall be filed with the State Agency for review by Federal and State auditors.
4. In the case of either a Title XVIII participating or other hospital, the Contractor, prior to making payments, shall conduct a study of hospital accounts of non-Enrolled Recipients and non-public assistance recipients in each participating hospital so as to verify and assure that charges to beneficiaries are not in excess of those for private patients admitted to the hospital, and shall periodically thereafter examine an adequate sampling of such hospital accounts for the same purpose. Contractor, however, may audit records of Eligible Providers pursuant to subparagraph A 13, of Article III.

B. PHYSICIAN'S SERVICES

Payments to physicians shall be based upon the amount of his usual and customary fee but not in excess of the reasonable charge, therefore, as defined in Article 2, paragraph 15, but in no event shall payments be in excess of an amount applicable to the service and set forth in Addendum 11 to this article.

C. SKILLED NURSING HOME CARE

1. Payments to a non-profit facility licensed or designated as a skilled nursing home, and to a county home or county hospital approved as a public medical institution shall be paid in the amount of reasonable costs.
2. Payments to a proprietary facility licensed or designated as a skilled nursing home (as this term is defined in Section II) shall be in the amount of costs or charges to private patients, whichever is lower. Charges and payments may be made for each day's care, or, on the same basis as in hospitals as in "A" above.
3. The Contractor, prior to making payments, shall conduct a study of skilled nursing home, county home, and county hospital accounts of non-beneficiaries and non-public assistance residents in each participating institution, and shall periodically thereafter examine an adequate sampling of such institutional accounts for the same purpose. Contractor may, however, audit pursuant to subparagraph A 13 of Article III.

D. HOME HEALTH CARE AND RELATED SERVICES

1. Payment to eligible Home Health Care Agencies, for visiting nurses, physical, occupational and speech therapists, audiologist, and home health aides, shall not be in excess of the reasonable costs of the provider of care giving service, or the general level of payments to similar providers of care in the community where costs are incurred, whichever is lower, but in no event shall payments be in excess of amounts established by the State Agency as maximum fees for the area in which services are provided.
2. Such maximum fee schedules as established by the State Agency shall be provided to the Contractor for purposes of audit of claims, but shall be held confidential by the Contractor, and shall not be published or released to providers of care or any other individual or group, nor shall the contents of such maximum fee schedules be revealed to any such individual or group.

3. Payment to curative workshops, voluntary home nursing agencies, official agencies and nonprofit home health care agencies, shall be made in an amount not in excess of the reasonable costs charged by the provider of care giving service, as established by fee schedules published or otherwise established by such providers of care for private patients and as approved by the State Agency. Contractor may audit, however, pursuant to subparagraph A 13 of Article III.

E. FEES FOR TREATMENT OF VERY DIFFICULT
OR COMPLICATED CONDITIONS

1. When the medical or dental condition of a recipient or beneficiary is unusually difficult or complicated and the treatment required necessitates a greater degree of time or skill than is ordinary for the condition, the maximum fee may be exceeded if justified by substantiating medical information.

F. MEDICAL CARE OR SERVICES PROVIDED
OUTSIDE OF THE STATE

1. Payments to eligible providers of care who are located outside of the state shall be made in the amount of the usual, customary, and reasonable cost or charges of the provider of care giving service, but not in excess of amounts established by the State Agency.

G. NURSES' SERVICES, PODIATRISTS' SERVICES, DENTISTS' SERVICES,
OPTOMETRISTS' SERVICES, DISPENSING OPTICIAN SERVICES,
MEDICAL SUPPLIES AND EQUIPMENT, INCLUDING RENTAL OF DURABLE
EQUIPMENT, AND TRANSPORTATION TO OBTAIN MEDICAL CARE

1. Payment for the above services shall not be in excess of the reasonable charges by the provider of care giving service, or the general level of payments to similar providers of care in the community where costs are incurred, whichever is lower and in no event shall payments be in excess of amounts established by the State Agency as maximum fees for the area in which services are provided.
2. Such maximum fee schedules as established by the State Agency shall be provided to the Contractor for purposes of audit of claims, but shall be held confidential by the Contractor, and shall not be published or released to providers of care or any other individual or group, nor shall the contents of such maximum fee schedules be revealed to any such individual or group.

I. PHARMACEUTICAL SERVICES

Payment to the Pharmacy will be based on acquisition cost of the drug, as defined by the State Agency, plus a dispensing fee.

ARTICLE V, ADDENDUM 3 - ILLUSTRATIVE UTILIZATION
CONTROLS AND CERTIFICATIONS

A. GENERAL

1. Within the context of this Contract, this term refers to the activity carried out by professional medical personnel in reviewing the records of patients', admissions, lengths of stay, overuse or underuse of consultations and whether required diagnostic workups and treatments were initiated and carried out promptly, etc.
2. This type of review also includes any pertinent statements as to what effect, if any, that hospital staffing may have on durations of stay, whether adequate assistance was available to the hospital, or program in arranging for discharge planning - such as the availability of out of hospital facilities, or home health care and services with which to assure continuity of care when needed.

B. UTILIZATION REVIEW PLAN

1. Hospitals (including tuberculosis hospitals and psychiatric hospitals) and skilled nursing homes, shall have in effect a plan for utilization review which applies, at least, to the inpatient services furnished to patients entitled to benefits under this contract. The plan must provide for review, on a sample basis, of admissions, durations of stays, and professional services furnished; and review of each case of continuous duration in excess of the average length of stay for all patients in the same hospital, during the patient's confinement. Further details on the requirements for an acceptable utilization review plan and guidelines for effectively meeting those requirements are given in the Social Security Administration's Regulations "Conditions for Participating Hospitals," and "Conditions for Participation, Extended Care Facilities." Effective utilization review must be maintained on a continuing basis to assure the medical necessity of the services for which the program pays and to promote the most efficient use of available medical care facilities and services.

C. CERTIFICATIONS AND RECERTIFICATIONS BY PHYSICIANS

1. Payment may be made for hospital services only if a physician certifies to the medical necessity for the services. For services continued over a period of time, a physician must recertify the continued need for the services at specified intervals. Appropriate supporting material may be required. Failure to obtain the required certification and recertification statements in an individual case may result in the hospital not being eligible to receive payment in that case.

The hospital must itself certify, on the appropriate billing form, that the required physician certification and recertification statements have been obtained and are on file. The physician certification and recertification statements will be retained in the hospitals' files, where they will be available for verification, if needed. Certification for inpatient hospital services (other than inpatient psychiatric or inpatient tuberculosis services) shall be required only with respect to continued hospitalization (see paragraph 3 below).

2. A hospital should also have available in its files a description of the procedure it adopts on the timing of recertifications for Title XIX patients, that is, the intervals at which recertifications will be required and whether review of long-stay cases by the utilization review committee will serve as an alternative to recertification by a physician in the case of the third or subsequent recertification.
3. Timing of Recertifications - The first recertification is required no later than as of the first day of hospitalization after the number of days of average patient stay shown for subject type of facility in the annual AHA "Guide Issue" of the Journal of the American Hospital Association for the State or geographical area involved. A hospital may, at its option, provide for the first recertification to be made earlier, or it may vary the timing of the first recertification within its average patient stay by diagnostic or clinical categories.
4. A hospital can, if it wishes, coordinate its physician certification with the process of review by the utilization review committee of long-stay cases. At the option of a hospital, review of a stay extended duration under the hospital's utilization review plan may take the place of the third and any subsequent physician recertifications. (Such review may be the initial review, or a second or subsequent review of an extended stay case by the utilization review committee.)
5. Need for Inpatient Hospital Services Certification - The inpatient hospital services certification should state the medical necessity for inpatient hospitalization. It will not be necessary to state the reason(s) why hospital admission is necessary unless for other than primary medical necessity. The certification of the medical necessity for inpatient hospital services should be signed by the admitting physician or a medical staff member with knowledge of the case.
6. Admission Procedure - Certifications may be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. However, the individual hospital can determine the method by which certifications are to be obtained and the

format of the certification statement. Thus, the medical and administrative staffs of each hospital may adopt the procedure they find most convenient and appropriate.

7. Recertification Statements for Inpatient Hospital Services - The recertification statement should meet the following standards: it should contain an adequate written record of the reasons for continued hospitalization, the estimated period of time the patient will need to remain in the hospital, and plans for post-hospital care. The recertification statement made by the physician should meet the content standards unless, for example, all of the required information is included in progress notes, in which case the physician's statement could indicate that the individual's medical records contains the information required by the standards and that continued hospitalization is medically necessary.

Recertifications are to be signed by the attending physician or a medical staff member with knowledge of the case. The hospital determines the form of the written record and the manner of obtaining timely recertifications. Thus, the hospital is able to adopt a procedure for obtaining timely recertifications that suits it best.

Where the requirements for the third or a subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the hospital's utilization review plan, a separate recertification statement is not required. However, it is necessary to satisfy the recertification content standards. It would be sufficient if records of the utilization review committees show that consideration was given to the three items mentioned above - the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and adequate plans for post-hospital care.

D. INPATIENT PSYCHIATRIC HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION.

1. The requirements for Psychiatrist (M.D.) certification and recertification for inpatient psychiatric hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differs from the content of the statements required for inpatient hospital services.
2. The certification should state that the inpatient psychiatrist hospital admission was medically necessary, for either (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.
3. The recertification should state (1) that the inpatient

psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either (a) treatment which could reasonably be expected to improve the patient's condition, or (b) diagnostic study; and (2) that the hospital clinical records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

For convenience, the period covered by the psychiatrist's certification and recertification is referred to as a period during which the patient was receiving active treatment. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's conditions, or because intensive treatment services are not being furnished), Title XIX program payment can no longer be made. Where the period of "active treatments" ends, the psychiatrist is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the psychiatrist should indicate, in making his recertification, the date on which it resumed.

E. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS FOR HOME HEALTH CARE SERVICES

1. Content of Physicians Certification - No payment can be made for Home Health Care Services unless a physician certifies that:
 - a. the home health services are or were required because the individual is or was confined to his home (except when receiving outpatient services);
 - b. the individual needed skilled nursing care on an intermittent basis or needed physical or speech therapy;
 - c. a plan for furnishing such services as to the individual has been established and is periodically reviewed by a physician; and
 - d. the services are or were furnished while the individual was under the care of a physician.

Since the certification is closely associated with the plan of treatment, the same physician who establishes the plan should also certify to the necessity for home health services. Certifications must be obtained at the time the plan of treatment is established or as soon thereafter as possible.

2. There is no requirement that the certification, or recertification discussed below, be entered on any specific form or handled in any specific way, as long as the Contractor can determine, where necessary, that the certification and

recertification requirements are met. The certification by the physician will be retained by the Home Health Care Agency, but the agency must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file in the agency when it forwards the request for reimbursement to the Contractor.

3. When services are continued for a period of time, the physician must recertify at intervals of at least once every two months that there is a continuing need for services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every two months) is required for the review of the plan. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertification is up to the individual agency.
4. The Home Health Care Agency should obtain certification and recertifications as promptly as possible. Payment will not be made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications must include an explanation for the delay and any other evidence the agency considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained, will be left to the Contractor.

ARTICLE V, ADDENDUM 4 - CLAIMS FOR SERVICES PROVIDED

A. CONTENT AND FORMAT

1. Contractor shall require providers to submit claims on a form designated by Contractor, except that hospitals may submit a part of the required billing information by attachment of a copy of their own patient ledger card to the form designated by the Contractor.
2. Billing Procedure - Contractor shall require hospitals which are Eligible Providers and which are participating in the Title XVIII program billing procedures to use billing forms for the Title XIX program similar to those used for the Title XVIII program.
3. The Contractor shall require Eligible Providers to submit a claim for services rendered to each Enrolled Recipient.
4. Submittal of Claims - Claims shall be submitted by Eligible Providers to the Contractor on a timely basis preferably once a week, unless the Contractor desires the provider to submit more frequently.

B. ITEMIZATION REQUIREMENTS

1. General Billing Requirements for All Eligible Providers - Provider's bill or claim for services rendered shall include:
 - a. name of the provider of care,
 - b. the date of the bill,
 - c. the name, and case number of the Enrolled Recipient who received care or services,
 - d. the type of such care or services provided,
 - e. the date(s) such care or services were given,
 - f. the amounts of the charges for the various types of care and/or services,
 - g. the total charge for care and/or services during the period, but only the period for which the Enrolled Recipient was certified as eligible,
 - h. credits for any payments made at the time of submittal of the bill, including payments made by private Health Insurance and under Title XVIII of the Social Security Act,
 - i. a certification by the provider to the effect that no supplemental charges beyond those established for medical needs, and shown as total charges on the claim to the contractor, have been or will be billed to the Enrolled Recipient for services provided,
 - j. a certification by the provider to the effect that by submittal of the claim the provider thereby agrees to abide by policies and procedures of the program as established by informational and instructional materials made available to him by the Contractor,
 - k. the fact that the Enrolled Recipient has health, accident, or other insurance policies or is covered by private or governmental benefit systems, and

1. in cases of terminal illness, the date of the Enrolled Recipients' death,
 - m. a statement somewhere on the claim form as follows: "The State Agency operates under the provisions of Title VI of the Civil Rights Act of 1964. Under the provisions of this Act, any provider of services receiving federal funds must comply with the intent of this Act and this means there shall be no discrimination because of race, color or national origin. This Title also provides for a strict compliance and complaint procedure."
2. Inpatient Hospital Care - In addition to general billing requirements, claims shall include the following information in addition to, a copy of the patient's itemized daily charges must be attached to the claim:
- a. date of admission and date of discharge (and inclusive dates during which service was rendered if charges are billed for period other than that beginning and ending with the date of discharge),
 - b. number of days care,
 - c. charges for bed, meals and nursing care,
 - d. discharge diagnoses (or diagnoses at end of period for which claim is submitted if discharge has not occurred), with primary diagnosis listed first,
 - e. when the diagnosis is tuberculosis or mental disease, the claim shall give the date such diagnosis was made,
 - f. type or surgical procedure, if any,
 - g. charges for ancillary services broken down between the following classifications:
 1. miscellaneous services;
 2. X-ray;
 3. laboratory;
 4. drugs
 5. dressings and supplies; and
 6. special services, PT, etc.

Allocation of charges between the various ancillary classifications shall be in accordance with the Hospital Billing Guide.

Each miscellaneous service and x-ray shall be identified as to type or kind and the individual charge shall be given. Identification as to kind may be by numerical or letter code in accordance with the Hospital Billing Guide.

Individual charges for other ancillary services (laboratory, drugs, dressings, and supplies) need to be specified and total charges for each of these classifications should be given.

- h. dates on which the various types of services were given. The posting date is satisfactory except when a portion of the period of care precedes or succeeds the certified period of eligibility. In such cases the actual date each of the above types of service was given must be recorded.
 - i. certification by the hospital that services provided were upon order of a specifically named physician or dentist.
3. Skilled Nursing Home Care - In addition to general billing requirements, claims shall include:
- a. the inclusive dates during which was provided,
 - b. the daily or weekly rate for bed and board at which billed, plus cost of special services provided on physician's orders,
 - c. if for a partial week's care, the portion of the week if billed at a weekly rate (i.e., 3/7 of a week) or the number of days if billed at a daily rate,
 - d. discharge diagnoses (or diagnoses at end of period for which claim is submitted, if discharge has not occurred), with primary diagnosis listed first,
 - e. when the diagnosis is tuberculosis or mental disease, the claim shall give the date such diagnosis was made,

- f. certification of the nursing home that services rendered were provided upon order of a specially named physician or dentist,
 - g. when the claim is for care in a county home, or city home, certification of a physician to the effect that the Enrolled Recipient is a "patient" in a "public medical institution" within the meaning of these terms as defined in Article II - DEFINITIONS.
4. Physicians' Services - In addition to general billing requirements, claims shall include the following information regarding the kind and amounts of care:
- a. visits by type; that is, whether hospital inpatient, skilled nursing home or public medical institution, or hospital outpatient, clinic, office, etc.
 - b. the type of each diagnostic, treatment, or surgical procedures; that is, the type or kind of each diagnostic x-ray, laboratory procedure, and the type of each surgical procedure performed.
 - c. the number of miles for which a travel charge is made,
 - d. the date on which each of the above services was provided,
 - e. the individual charge for each of the above services,
 - f. the diagnoses of the condition(s) for which treatment and services were provided.

Bills shall also include any pertinent supplemental information, including clarification of the diagnoses in terms of the degree or extent of involvement, in so far as necessary to substantiate the need for the services rendered and/or charges made.

5. Dentists' Services - -
In addition to general billing requirements, claims shall include the following information:
- a. specification of each service rendered showing "number(s) of the tooth or teeth involved in

accordance with the attached chart." The "Claim for Dentists' Services" form must incorporate such a chart,

- b. in the case of fillings, the charting, and specification of cavity locations will be recorded on a chart which is part of the form "Claim for Dentists' Services,"
 - c. the date each service was rendered,
 - d. the charge for each service rendered.
6. Outpatient Services Provided Through a Hospital or by a Physician in a Hospital - In addition to general billing requirements, claims shall include the following information:
- a. type or kind of surgery or surgical procedure,
 - b. type or kind of medical treatment,
 - c. charges for each type of service,
 - d. date of outpatient visit,
 - e. treatment diagnoses with primary diagnosis listed first.
7. Home Health Care Services - In addition to general billing requirements, claims shall include the following information:
- a. specification of services provided by each home health visit, by visits, hours, days, type of procedure, etc.
 - b. date of each home health visit,
 - c. charge for each home health visit,
 - d. supplies and equipment provided with charge for each item,
 - e. certification by the home health agency that services provided were prescribed by a specifically named physician, and that they were performed under the supervision of a physician, registered nurse, or

by a practitioner, e.g., physical therapist, etc.

8. Diagnostic X-rays or Laboratory Procedures - In addition to general billing requirements, claims shall include the following information:
 - a. the type or kind of each diagnostic x-ray or laboratory procedure.
 - b. the date each such service was provided,
 - c. the charge for each such service,
 - d. the diagnoses or tentative diagnoses of the condition(s) for which services were provided.
9. Pharmaceutical Services - In addition to general billing requirements, drug claims shall include the following information for each prescription filled or refilled.
 - a. prescription number (indicate if renewal),
 - b. doctor's name or identification number,
 - c. date service rendered by pharmacy,
 - d. name, strength, and dosage, and direction for use of drug dispensed (or code number where applicable),
 - e. quantity of drug dispensed,
 - f. name or code number of manufacturer, (if not included in the drug code number)
 - g. acquisition cost of drug,
 - h. dispensing fee,
 - i. total of acquisition cost plus dispensing fee (for non-legend items or accessories, this is to be the ordinary and customary charge made for such items to the general public - give charges as "total" only - do not add fee.)
 - j. signature of pharmacist (owner or manager) submitting claim.

10. Optometrists' Services - In addition to general billing requirements, claims shall include the following information:
 - a. specification of services provided,
 - b. description of frames and prescription of lenses provided,
 - c. date services or items were provided,
 - d. charge per services or items provided.
11. Eyeglasses Prescribed by a Physician Skilled in the Diseases of the Eye or by an Optometrist - In addition to general billing requirements, claims shall include the following information:
 - a. specification of services provided,
 - b. description of frames and prescription of lenses provided,
 - c. date services or items were provided,
 - d. charge per services or items provided,
 - e. when provided by a dispensing optician, certification that glasses were prescribed by a specifically named physician or optometrist.
12. Medical Supplies and Equipment, including Rental of Durable Equipment - In addition to general billing requirements, claims shall include the following information:
 - a. specification of item provided,
 - b. specification that provided on a rental basis, if so,
 - c. quantity of item provided,
 - d. date item provided,
 - e. charge per item,

- f. an exact copy of the physician's prescription or order, as an attachment to the claim, together for refilled prescriptions or orders, with date refilled and the number of times refilled,
 - g. for registered pharmacies, when medical supplies prescribed earlier are provided on the basis of a subsequent order for continuing use, such order shall be handled as a new prescription by giving it a new number, and date, and an exact copy of this prescription shall be attached.
- 13. Prosthetic Devices - In addition to general billing requirements, the following information:
 - a. specification of items provided,
 - b. charge per item,
 - c. date item provided,
 - d. an exact copy of the physician's prescription or order as an attachment to the claim.
- 14. Other Diagnostic, Screening, Preventive or Rehabilitative Services - In addition to general billing requirements, claims shall include the following information:
 - a. specification of procedures, tests, items, supplies or services provided,
 - b. date provided,
 - c. charge per procedure, test, item, supply or service provided.
- 15. Transportation to Obtain Medical Care - In addition to general billing requirements, claims shall include the following information:
 - a. specification of kind of transportation, i.e., ambulance or automobile,
 - b. flat rate and/or number of miles traveled, one way,
 - c. specification of other services provided in connection with such services, i.e., cost of an attendant, or meals of recipient, driver or attendant.

ARTICLE V, ADDENDUM 5 - AUDIT OF CLAIMS FROM PROVIDERS

A. GENERAL

Contractor shall employ a physician, or physicians as necessary and such medical technicians as necessary, to supervise audit of claims for services rendered, and payments to Eligible Providers, and to develop and maintain necessary safeguards to assure the quality and quantity of care, and shall in addition have available as consultants for similar purposes a dentist(s) and pharmacist(s), etc.

B. AUDIT OF CLAIMS FOR SERVICES PROVIDED

Contractor shall develop and maintain methods of audit and analysis of claims which will reveal any excessive utilization of medical care and services on the part of any Enrolled Recipient or Provider, or unsound or unethical practice on the part of any Provider.

1. Auditing Procedures - Contractor, prior to making final payment to Providers of health care services, shall audit all claims for services rendered so as to:
 - a. Assure that claims are complete, accurate and in proper form, in accordance with the claim requirements of Addendum 4;
 - b. Assure that payment will be made only to Eligible Providers as defined in Article II;
 - c. Assure that payments will be made only for those benefits specified in Article IV, subject to the exclusions and limitations as stated therein;
 - d. Assure that medical care and services for which payments are made were medically necessary for diagnosis or treatment, or both, of the condition for which benefits were provided and proper in accordance with the diagnosis of this condition, and that they were prescribed by a physician or doctor of dental surgery, as appropriate to the particular benefit, in accordance with the requirements of Article IV;
 - e. Assure, when claims are made in respect to an Enrolled Recipient who is confined in a public institution, that no payments will be made for any medical care and services furnished in a non-medical public institution as defined in Article II;
 - f. Assure that Providers will be paid in accordance with the requirements of Addendum 2 of Article V;

- g. Identify cases where quality of service rendered or ethical practices of the Provider are in question.
2. Questionable Claims - All questionable claims shall be reviewed by the physician(s), dentist(s), or pharmacist(s) as appropriate, who is employed by or available to the Contractor as a consultant for:
- a. Interpretation of benefit coverage with respect to "illness," "one illness," or "mental disease" as these terms are defined in Section II;
 - b. Determinations on questions regarding overutilization of services by Enrolled Recipients or providers;
 - c. Determinations on questions regarding excessive charges by providers;
 - d. Determination of the maximum fee to be paid when a claim is made for a procedure or service for which a maximum fee has not been established by the State Agency; such determination to be made on the basis of usual, customary, and reasonable charges and in comparison with established maximum fees for other procedures requiring similar degrees of skill, training or experience;
 - e. Review and investigation of quality of care provided and of unethical practices of providers. Summary reports on such situations, accompanied by photocopies of applicable claims, shall be furnished to the State Agency.

The State Agency Technical Medical staff, including the Medical Director shall be available as requested for consultation with the Contractor in relation to such questionable claims.

C. PAYMENT TO PROVIDERS

- 1. Frequency of Payment - The Contractor shall make prompt payment to provider customarily within a thirty day period after receipt of the claim, or receipt of eligibility status of Enrolled Recipient, whichever is the latter.
- 2. Notification to Providers - In making payment of claims the Contractor shall identify for the provider the Enrolled Recipient on whose behalf payment is made, and the period of care for which payment is made. If, as a result of auditing process, there are alterations in the amount of allowable charges of a provider, the Contractor shall notify the provider of care of the adjustment and the reason it was made.

ARTICLE V, ADDENDUM 6 - ACCOUNTING DATA - MUTUAL REPORTING REQUIREMENTS

A. CONTRACTOR'S MONTHLY MEDICAL ASSISTANCE LISTINGS

1. The Contractor on a monthly basis or other appropriate longer interval shall for each Medical Assistance category submit an itemized list in Medical Assistance case number order, of all claims paid in the week or month, by county, each county on a separate sheet. Each listing will be supported by paid claim data routinely prepared by the Contractor. Specifications as to information required are set forth in Addendum 4, of Article V. In addition, each listing will show:
 - a. Month of payment;
 - b. Case number of Enrolled Recipient
 - c. Name of Enrolled Recipient on whose behalf medical care benefit payments were made;
 - d. Name and/or number of the provider for each care or service benefit payment;
 - e. Amount of each medical care benefit payment;
 - f. Grand total of payments in behalf of each Enrolled Recipient;
 - g. Unduplicated count of the number of Enrolled Recipients for each county;
 - h. Total amount of all payments for each county, classified and identified by type of benefit according to code numbers, as follows:
 - 01 - inpatient hospital care
 - 02 - skilled nursing home care
 - 03 - physicians' services
 - 04 - dentists' services
 - 05 - pharmaceutical services
 - 06 - home health care services
 - 07 - outpatient hospital care
 - 08 - therapy
 - 09 - mental hospital care
 - 10 - optometrist
 - 11 - other
 - 12 - x-ray and laboratory services
 - 13 - transportation
 - 14 - prosthetic devices
 - 15 - medical supplies and equipment
2. One copy of the above listing with supporting data will be sent to the State Agency.

B. WEEKLY MEDICAL CARE PAYMENTS LISTING (By Provider)

1. The Contractor on a regular basis shall submit an itemized listing, in provider case order, of all claims paid, by county, each county on a separate sheet, such listing to include:

- a. Month of payment;
- b. Provider number;
- c. Name of Provider;
- d. Total care payments to each provider;
- e. Total number of claims paid, by provider;
- f. check number for each payment;
- g. Grand total of:

(1) Work units

(2) Amount of payments

This should agree with the total amount included in the Weekly Medical Assistance Listings.

2. Three copies of this listing shall be submitted to the State Agency.

C. STATE AGENCY'S LISTING OF CERTIFICATIONS

1. The State Agency shall provide the Contractor weekly or daily with a listing of Enrolled Recipients' name and address, in Enrolled Recipient case number order, by county, each county on a separate sheet for:

- a. New certifications of eligibility, effective date, and other benefits available;
- b. Expirations of certifications of eligibility, and effective date;
- c. Cancellations of certifications of eligibility, and effective date;
- d. Recertifications of eligibility, effective date, and other benefits available.

One copy of these listings shall be submitted to the Contractor.

2. Where feasible the State Agency should provide the Contractor daily with an eligibility magnetic tape to update the Contractor's file.

3. The State Agency shall maintain in useable form such information as is necessary for analysis of the volume of different types of medical care benefit provided to each Enrolled Recipient, and the cost thereof, and of the volume of different types of care and service benefits provided by each provider, and the cost thereof.

ARTICLE V, ADDENUM 7 - ACCOUNTING ALLOCATIONS

A. GENERAL

It is understood and agreed that the Blue Cross and Blue Shield Accounting Manual shall serve as a basic document for use in establishing uniform expense classifications, groupings, cost centers and principles of expense allocations, subject to the adjustments specified under Addendum 8.

B. Administrative expenses incurred in connection with the administration of the contract may either be:

1. Direct - Any items of expense uniquely attributable to, and incurred for the specific benefit of, this Contract.
2. Indirect -
 - a. Any item of expense which benefits both this Contract and other work and can be distributed to them in reasonable proportion to the benefits received; or
 - b. Is necessary to the overall operation of the business, although a direct relationship to any particular cost objective cannot be shown.
3. Accounts Requiring Special Consideration - The following accounts require special consideration in determining Plan administrative cost of the Contract;

7.01 Advertising

Payment is permitted for only three types of advertising, as follows:

- a. Advertising costs, including corollary administrative costs, in connection with:
 - (1) The recruitment of personnel required for the performance of obligations arising under the agreement, when considered in conjunction with all other recruitment costs;
 - (2) The procurement of scarce items for the performance of the agreement; or

- (3) The disposal of scrip and surplus materials acquired in the performance of the agreement.
- b. Public informational costs in the mass media where incurred in joint State Agency and intermediary informational activities. Mass media, for this purpose, shall mean all media to which the general public has unrestricted access, e.g., newspaper, magazine, radio, television, public exhibition, etc.
- c. Public informational costs in restricted media are allowable if:
 - (1) The reasons for incurring the costs are directly related to performance under the agreement;
 - (2) The type and content of the information for which the costs are incurred have been approved by the State Agency; and
 - (3) They do not include the costs of disseminating the information to a non-program related audience reached by the media, nor the costs of disseminating non-program information to the program related audience reached by the media.

Restricted media, for this purpose, shall mean any media to which only specific audiences, selected by the distributor, have access, e.g., professional journals, meetings and conventions, limited direct mailing, etc.

7.08 Boards, Bureaus and Associations

National advertising contributions paid to the Blue Cross Association are not an Allowable expense and must be excluded from charges to the Title XIX program. A proportionate share of dues payable to the Blue Cross Association and the National Association of Blue Shield Plans are allowable as allowable administrative expense.

7.12 Commissions

Commissions or allowances made to agents or other

representatives for the purpose of maintaining or securing business for the Contractor is not an allowable administrative expense.

7.23 Depreciation - Automobiles

Depreciation and use charges are allowable elements of cost, with limitations, as described under 7.33 Depreciation of Equipment.

7.28 Occupancy of Plan Owned Real Estate

The Contractor may elect to charge occupancy costs, a charge in the nature of rent, as an allowable administrative expense in lieu of real estate expense, including depreciation and all other costs incident to the ownership and operation of real estate only if proportionally charged to all other lines of business. The use of a rent charge would allow the Contractor to receive a return on capital invested in fixed assets. Charges in the nature of rent, for use of Contractor owned real estate, may be made even though such charges are not a normal accounting practice of the Contractor provided that such charges are included in the State Insurance Report or other governmental documents that must be filed annually by the Contractor. The annual charge per square foot allocated to this Contract should be comparable to an established market rate for the type of space involved and for the location of the building.

7.29 Charges in the Nature of Rent - Equipment

The Contractor may elect to make a charge in the nature of rent as allowable administrative expense in lieu of all costs incident to the ownership and operation of equipment only if proportionally charged to all other lines of business. The use of a rent charge would allow the Contractor to receive a return on capital invested in fixed assets.

Charges in the nature of rent for Contractor owned furniture and equipment, may be made regardless of whether such charges are a current accounting practice or included in the State Insurance Report or other governmental documents that must be filed annually by the Contractor.

Reasonable charges for use of the Contractor's assets which have already been fully depreciated may be made only if proportionally charged to all other lines of business. Such

charges are similarly allowable for the use of assets that become fully depreciated some time after entering into the agreement, but which were only partially depreciated prior to entering into this Contract.

Normally, use charges are limited to 50 per cent of the annual straight line depreciated computed on the basis of the original estimated useful lives of the assets.

Use charges are defined as follows:

- a. In determining the amount of proper use charge, consideration should be given to the cost of acquisition, the remaining useful life at the time of negotiation, the actual replacement policies of the Contractor, and the effect of increased maintenance charges or decreased efficiency due to age. The annual straight line depreciation charge may be used as a base for computing a proper use charge. Due to decreased efficiency and higher maintenance charges, the annual use charge normally would not be expected to be more than 50 per cent of the original annual depreciation charge, unless the Contractor can show that such a reduction is unreasonable or otherwise unwarranted.
- b. An alternate method of computing a proper annual use charge is, when the asset has been fully depreciated, to divide the estimated residual value of the asset by the estimated remaining useful life. For example, if a \$10,000 asset has been fully depreciated over ten years, its estimated residual value might be 25 per cent of its acquisition cost and its estimated useful life 50 per cent of its originally depreciable life. The resulting annual use charge of \$500 is equal to one-half of the original straight line depreciation (25 per cent of acquisition cost spread over 50 per cent of original useful life will always yield one-half of the original straight line depreciation). Any computation of use charges under this paragraph is subject to the limitations of paragraph "a" above.

If a Plan capitalizes the furniture and equipment, then any depreciation must be applicable to Title XIX on the same formula as charged to all lines of business.

If a Plan writes furniture and equipment off at the time of purchase, the same practice and accounting procedure must be followed for Title XIX.

7.32 Equipment Expense (when capitalized)

Equipment costing \$50.00 or more per item and having a useful life of more than one year may be charged off as an expense in the year of purchase. Thus, only items of equipment costing less than \$50.00 should be charged to this account; all other equipment charges to this account must be removed.

7.33 Depreciation of Equipment (when capitalized)

Normal depreciaton, computed on the cost of an asset, is an allowable element of administrative expense.

Depreciation is defined as follows:

- a. Depreciation is a charge to current operations which distributes the cost of a tangible capital asset, less estimated residual value, over the estimated useful life of the asset in a systematic and logical manner. It does not involve a process of valuation. Useful life refers to the prospective period of economic usefulness in the Contractor's operation as distinguished from physical life.
- b. For purposes of this Contract, the Contractor must depreciate all items of equipment having a useful life of more than one year. The cost of equipment may not be charged off as an expense in the year of purchase. However, the Contractor may expense minor items of equipment up to a unit cost of \$50 per item. Where depreciation is introduced for application to assets acquired in prior years and charged to expense at the time of purchase, the annual charges therefrom must not exceed the amounts that would have resulted had the depreciation method been in effect from the date of acquisition of such assets. Where necessary, it is anticipated that the Contractor will establish memorandum accounts on the various items of classes of equipment and determine, for contract administrative expense purposes, the amount of depreciation which would have been allocable to the contract if the Contractor had been subject to taxation under the Internal Revenue Code of 1954, as amended.

- c. Normal depreciation on the Contractor's plant, equipment and other capital facilities is an allowable element of administrative expense if the amount is computed:
- (1) In the case of non-profit or tax-exempt organizations, upon a property cost basis which could have been used by the Contractor for Federal income tax purposes, had such organizations been subject to the payment of income tax; and
 - (2) By the consistent application to the assets concerned of any generally accepted accounting method, and subject to the limitations of the Internal Revenue Code, as amended.

7.50 Legal Services

Legal Services incurred specifically for subrogation activities are not allowable. However, an appropriate portion of costs for legal services of a general corporate nature are allowable.

7.56 Actuarial Services

Consulting actuary services incurred in connection with the establishment of Contractor prepaid charge and experience tables for this contract are allowable.

The cost of actuarial services incurred for special actuarial studies performed at the request of the State Agency is allowable. Prior approval of the State Agency is required for such expenditures. Whenever a consulting actuary is used on a special project for this Contract, the actuary should be instructed to identify separately on the invoice submitted to the Contractor those charges incurred on the special project.

7.60 State and Local Insurance Taxes

These taxes will not be allowable unless the calculation of the tax includes amounts attributable to this Contract.

7.70 Real Estate Expense

To the extent that costs charged to real estate expense represent the cost of owning and operating property for the Plan's own use, i.e., ownership costs, an appropriate portion of the cost is an allowable administrative expense. However, to the extent that these expenses relate to properties owned and operated as Contractor investments, such expenses must be eliminated from the following accounts before real estate expense is allocated:

- 7.72 - Maintenance and Repairs, Real Estate
- 7.73 - Depreciation, Real Estate
- 7.74 - Insurance, Real Estate
- 7.75 - Utilities, Real Estate
- 7.76 - Management Fees, Real Estate
- 7.78 - Real Estate Taxes

When account 7.28, Occupancy of Plan Owned Real Estate, is used and an Occupancy charge is made to the Program in lieu of real estate expense, no portion of real estate expense is an allowable administrative expense.

7.73 Depreciation - Real Estate

Depreciation is an allowable administrative expense. See account 7.28, Occupancy of Plan Owned Real Estate, for use of rent in lieu of depreciation.

7.80 Investment Expense

Cost of investment services should not be included.

7.82 (8.02) Services Charges (and Credits) - Inter-Plan Service

Benefit Bank - Operating expenses and service charges or credits for Home cases charged to the Contractor by the Blue Cross Association should not be included unless this Contract utilizes such system.

7.83 (8.03) Service Charges (or Credits) -
Reciprocal Cases

These service charges or credits should not be included.

7.84 Allocated Expenses -
Federal Employee Program

Amounts charged to this account should not be included.

7.85 (8.05) Syndicate Service Charges (or Credits)
Participating (or Control) Plan

Syndicate administrative allowances incurred by the Contractor serving as a Control Plan should not be included.

7.87 Interest Expense

Interest expense paid or accrued on working capital loans should not be included.

7.88 Miscellaneous Expense

Certain items, which may be charged to this account, are not allowable administrative expenses. These items are:

- uncollected subscriber's dues charged off, including any related collection charges.

Reimbursements for services and any credits against expenses listed below should be deducted from allowable administrative expense to the extent the expense was charged to this Contract.

- 8.06 Service Credits -- Blue Cross/Blue Shield Counterpart
- 8.10 Federal Employee Program -- Supplemental Expense Reimbursement
- 8.11 Dependents Medical Care Administrative Allowance
- 8.20 Miscellaneous Expense Reimbursements
- 8.21 Cafeteria Sales

ARTICLE V, ADDENDUM 8 - OPERATIONS

The following guidelines should be used to determine which activities are chargeable to this Contract. The Operations listed conform to the Blue Cross and Blue Shield Accounting Manual.

A. EXECUTIVE OPERATION

1. Include the cost of:

- a. An executive responsible for all functions and operations.
- b. Executives responsible for two or more operations.
- c. Staff assistants and secretaries to be foregoing.
- d. Any expense incurred in carrying on a corporate business, such as Board of Directors and committees thereof, legal counsel, association dues, etc.
- e. Personnel.
- f. Research (Basic).

2. Basis of Distribution to this Contract

- a. If the Personnel Department spends an equal amount of time on all employees, then the expense of this cost center may be allocated to this Contract in the same ratio as the salaries charged to this Contract bears to the overall salaries of the Contractor. Any other basis that produces substantially the same result is also acceptable.
- b. The remaining costs under the Executive Operation are usually of a general corporate nature and may be allocated to this Contract based on time reports or studies, employee or salary ratio, or other appropriate bases. The "employee or salary ratio" is the number of employees or salaries allocated to this Contract expressed as a percentage of the total number of employees or salary, excluding those employees or salaries in the cost centers which are also to be allocated on the employee or salary ratio basis.

B. ENROLLMENT OPERATION

1. Exclude the cost of:

All enrollment expenses. Expenses of the Enrollment Operation are not allowable. Subscriber (Enrolled Recipients) service costs, supported by time records, are allowable under this operation.

C. PUBLIC RELATIONS OPERATION

1. Include the cost of:

- a. Preparation of house organs.
- b. Preparation of news releases, articles, or reports of a general corporate nature.
- c. Promotional and publicity costs for which a relationship to this Contract can be demonstrated. For example, the costs of advertising for the purpose of educating providers as to the requirements of the Program are allowable.

2. Exclude cost of:

- a. Preparation and cost of advertising and enrollment promotional materials, including outside printing and publication costs.

3. Basis of Distribution

- a. Time reports or studies will be needed to determine the portion of Public Relations cost attributable to the allowable activities.
- b. Employee or salary ratio is an acceptable basis for allocating the cost of allowable activities to this Contract.

D. SUBSCRIBER ACCOUNTING OPERATION

1. Include cost of:

- a. Handling correspondence, telephone calls and personal

interview with subscribers.

b. Maintenance of a central status file for Eligible Persons or the processing of status queries if the State Agency maintains the file.

c. Processing cash received under this Contract.

2. Exclude cost of:

a. Preparation and processing of group and direct pay bills.

b. Reconciling, adjusting and refunding of subscriber remittances.

c. Processing contract conversions and changes.

d. If a separate eligibility file for Title XIX is maintained, then maintenance of central application or status file for regular subscribers is not allowable. If Title XIX is incorporated or part of the central application or status file, then a prorated share shall be charged to this contract.

e. Processing Inter-Plan transfers, in and out.

3. Basis of distribution to this Contract:

a. Separate cost centers, time reports or time studies will be needed to determine the cost of the allowable activities.

b. Number of letters, telephone calls or interviews with Eligible Persons are acceptable bases for allocating the cost of Subscriber Service activities to this Contract.

E. CLAIMS OPERATIONS

1. Include cost of:

a. Examination, approval or rejection and medical review of claims.

b. Payment, verification and servicing of claims.

c. Answering inquiries about the payment or rejection of claims.

- d. Utilization control, including expenses of hospital and physician review committees.
- e. Maintenance of claims history file, including status information only for claims processed by the Contractor.

2. Basis of distribution to this Contract.

- a. For those activities where there is a significant difference in processing cost, separate cost centers, time reports or studies will be used to determine the portion of the cost of those activities chargeable to this Contract.
- b. Number of claims paid is an acceptable basis for allocating the cost of those activities where there is no significant difference in claims processing cost between this Contract and other business of the Contractor, e.g., utilization control.

F. PROFESSIONAL OR HOSPITAL RELATIONS OPERATION

1. Include cost of:

- a. Contacting, in a professional capacity, physicians or hospitals and their staff for the purpose of assisting them in functioning effectively and efficiently in behalf of beneficiaries.
- b. Providing assistance in handling specific claims problems.

2. Basis of distribution to this Contract:

- a. Number of paid claims, time reports or time studies is an acceptable basis.

G. FINANCIAL OPERATION

1. Include cost of:

- a. Maintenance of general and subsidiary ledgers.
- b. Preparation of statements and reports

- c. Cost accounting
- d. Disbursements
- e. Payroll
- f. Budgeting
- g. Internal and external auditing

2. Exclude cost of:

- a. Investment management.

3. Basis of distribution to this Contract

- a. Examples of costs directly chargeable to this Contract are:

- (1) Preparation, submission and control of paid claim cards, invoices and reports to the State Agency.

- (2) Preparation of cost submission reports.

- b. If the costs for the above items are charged directly to this Contract, then the Contractor shall exclude the same types of cost directly chargeable to the Contractor's other lines of business before allocating the remaining indirect costs to this Contract.

- c. Number of claims paid is an acceptable basis for allocating the Claims Processing portion of the cost of allowable activities.

- d. Time reports, Employee ratio or salary ratio is an acceptable basis for allocating the General Office portion of the cost of allowable activities.

H. ACTUARIAL AND STATISTICAL OPERATION

1. Include the cost of:

- a. Any statistical or research studies requested by the State Agency.
- b. Compiling and reporting operating statistics, including data on volume of bills processed, benefits paid, etc.
- c. Maintenance and reporting of exposure statistics.
- d. Determination of reserves for unreported claims.

- c. Actuarial, statistical and research work in developing a new or improved product, procedure, or device which will be of general use to the Contractor and which is not chargeable to a specific line of business.
- 2. Exclude the cost of:
 - a. Calculations involved in determining group and direct pay subscription rates, including merit or experience rating.
 - b. Underwriting, both Group and Direct Pay.
- 3. Basis of distribution to this Contract:
 - a. Work measurement, time reports, time studies, number of claims paid, or other analytical processes should be used as appropriate to determine the portion of cost of allowable activities chargeable to this Contract.

I. DATA PROCESSING OPERATION

- 1. Include the cost of:

All operating punched card or electronic equipment, programming, and systems and procedures as a service to other departments in the performance of those activities listed above as allowable items.
- 2. Exclude the cost of:

Service functions for those activities excluded under the foregoing operations.
- 3. Basis of distribution to this Contract:
 - a. A machine time reporting system, or time studies, will be needed to determine the service costs attributable to the allowable activities included under the foregoing Operations.

- b. The portion of Data Processing cost attributable to each allowable activity listed under the foregoing Operations should be allocated to this Contract on the same basis as the other costs of that activity.

J. OFFICE SERVICES OPERATION

1. Include the cost of:

All cost of the Mail, Stock, Printing, Microfilm, etc. functions operated as a service to the other departments in the performance of those activities listed above as allowable items.

2. Exclude the cost of:

Service functions for those activities excluded under the foregoing Operations.

3. Basis of distribution to this Contract

- a. Separate cost centers, time reports or time studies will be needed to determine the cost of the various functions included under Office Services in the Accounting Manual.
- b. The various unit counts suggested in the Accounting Manual are acceptable to the allowable activities included under the foregoing Operations.
- c. The portion of Office Services cost attributable to each allowable activity listed under the foregoing Operations should be allocated to this Contract on the same basis as the other costs of that activity.

ARTICLE V, ADDENDUM 9 - REPORT REQUIREMENTS

A. GENERAL PRINCIPLES AND PURPOSE

These requirements are set forth:

1. To provide proper and efficient medical care administration of the Title XIX Program by both parties to the Contract with a minimum of reporting requirements.
2. To provide high quality medical care and services within the mainstream of medical practice for usual, customary, and reasonable cost or reasonable charges -- as the case may be.
3. To provide simplification of the information reporting process - between Providers and Contractor, as well as between Contractor and State Agency.
4. To allow adequate consideration for the proper implementation of the State Plan by the State Agency. This principle demands strict adherence to the Single State Agency concept that responsibility for the program's expenditures and effectiveness rests statutorially with the Single State Agency designated by the State Governor, and that this responsibility cannot be delegated. The State Agency, however, may delegate the administration of certain duties, functions, and operations by contract; but such delegation in no way relieves the State Agency of its responsibilities to the State's taxpayers, to their elected State and Federal officials, or to the Federal Government.
5. To insure that neither the State Agency, the Contractor, the Eligible Providers of service, nor the Enrolled Recipients are disadvantaged by obscure or ill-defined contractual assignments of duties, functions or operating procedures, or both, to either the Contractor or State Agency.

B. METHOD OF ACCOMPLISHMENT

1. To the extent possible this Contract anticipates most of the various items of information needed for the management of the cost, quantity, and quality of care purchased from providers through the Contractor. See Addendum 10 for a summary of types of information needed by a State Agency's medical care administration unit.
2. All of the input of essential information relating to Enrolled Recipients and Eligible Providers is obtained by designing its introduction into the benefit authorization and Eligible Provider payment systems on a one-time basis at the lowest possible level.
3. To the extent possible, each level of administration is provided enough information to accomplish the necessary medical audits,

management audits, and fiscal audits for proper and efficient administration without asking the Contractor or the providers for the same or similar information in varying formats.

4. Specifically, each level of administration in the Contractor's organization and the State Agency is to be provided with enough information in the form of completed billing documents and punched cards, disks, or tapes (whichever is available) to set up a master index file of all patients and providers on an individual basis so it can accomplish mechanically the reviews and audits essential to that level of operation.

C. RESPONSIBILITIES OF THE MEDICAL CARE ADMINISTRATION UNIT OF THE SINGLE STATE AGENCY WHICH MAY NOT BE DELEGATED BY CONTRACT OR AGREEMENT

1. Whenever a single State Agency proposes to contract out part of its functions, the Contract has to include sufficient details as to permit the single State Agency's Medical Care Administration Unit to:
 - a. Obtain and evaluate expenditure data relating to individual patients;
 - b. Obtain and evaluate data relating to deductibles and coinsurance paid, and supplementation charges made to individual patients;
 - c. Obtain and evaluate utilization data relating to diagnoses, treatments, and other services provided individual patients;
 - d. Obtain sufficient data to insure that case management services regarding medical social work are known and planned for when needed;
 - e. Furnish professional and technical consultant services to non-medical units of the parent agency and to the Contractor;
 - f. Utilize technical advisory committees of the organized professional associations to assist in the establishment and continued improvement of the programs;
 - g. Interpret the program to public and voluntary associations and agencies at various related community levels;
 - h. Maintain close working relationships with various organized professional associations and public and voluntary associations and agencies at all related community levels;
 - i. Develop recommendations as to acceptable reimbursement formulas and compensation rates, for "Reasonable Costs and/or charges;"
 - j. Develop program utilization control factors, e.g., variations in modules of benefits, in drugs, in services, etc.;

- k. Evaluate the program's effectiveness as it relates to the adequacy of the individual benefits provided;
 - l. Prepare budget estimates and make appropriate budget requests for fiscal and contract periods;
 - m. Initiate and negotiate with providers and Contractors possible benefits and changes and their costs to the program;
 - n. Insure that providers are paid promptly for authorized services by the Contractor through insuring that eligibility information is available without delay;
 - o. Approve the standardization of forms, records, reports, and operating procedures to the extent practicable;
 - p. Prepare quarterly and annual reports on the persons served, the services rendered, and a simplified analysis of the expenditures made under the Title XIX program;
 - q. Insure that appropriate action is taken with respect to utilization problems and that refunds are obtained or credited when funds are improperly expended on the basis of claims made by vendors.
 - r. Make known to providers that utilization reviews and controls are an ongoing process;
 - s. Utilize professional peer review bodies to examine cases and render valid medical opinions in the light of the medical community's practices.
2. Article V and Addenda 1 through 5 contain sufficient details to comply with C - 1 above.

ARTICLE V, ADDENDUM 10 - SUMMARY OF INFORMATION NEEDED BY A STATE AGENCY'S
MEDICAL ASSISTANCE UNIT FOR TITLE XIX EVALUATION

A. BASIC DATA FILES

These data are divided into three major units of information. Only when all three are combined through ADP/EDP programming applications, are adequate control, evaluation, and cost management techniques applicable and available to the extent desired to meet Title XIX requirements.

1. Minimum "identification data" needed to provide a cross-index base for combining with data listed in 2 and 3 as well as any social data needed from casework files.
2. Individual "medical records data" needed for medical auditing of diagnostic data, treatment data, and utilization data.
3. "Provider data" needed to accomplish fiscal audits, and program management audits to evaluate quantity, quality and cost of care.

B. AUTOMATED INFORMATION FILES

1. INDIVIDUAL IDENTIFICATION DATA

- a. Case number/social security number
- b. Name
- c. Program category
- d. County/municipality
- e. Sex
- f. Marital status
- g. Date of birth
- h. Last address
- i. Resources/type/source

2. INDIVIDUAL MEDICAL CARE AND TREATMENT DATA

a. In a hospital and/or skilled nursing home

- (1) Register number/facility identification/case number/
social security number
- (2) Dates of admission/discharge
- (3) Authorized/certification of medical need
- (4) Emergency addressee
- (5) Program category
- (6) Diagnoses
 - (a) Admission
 - (b) Discharge
- (7) Type of admission by service
 - (a) Inpatient (type)
 - (b) Outpatient (see b. below)
- (8) Source of referral and doctor identification
- (9) Attending physician identification

- (a) Utilization reviews
- (10) Treatment/drugs
- (11) Services, e.g., rehabilitation, PT, OT, etc.
- (12) Procedures
- (13) Operations - major/minor
- (14) Consultations
- (15) Diagnostic studies - lab, x-ray, etc.
- (16) Frequency of physician's care
- (17) Discharge planning
- (18) Prognosis at discharge
- (19) Status at discharge/death/transfer
- (20) Amounts of charges for various types of care and services
- (21) Invoice number and date of service
- (22) Credits for any payments made against bill

b. Out of Hospital Care and Service Data

- (1) Case number/SSA number
- (2) Physician or other practitioner
 - (a) Home/cost or charge
 - (b) Office/cost or charge
 - (c) Clinic/cost or charge
- (3) Screening
- (4) Examination
- (5) Diagnosis
- (6) Treatment
- (7) Referrals
- (8) Invoice number/date of service

c. Drug Utilization Data

- (1) Case number/SSA number
- (2) Doctor-identification number
- (3) Pharmacy
- (4) Drug name/strength/form/log no./dosage
- (5) Quantity
- (6) Date filled
- (7) Refilled
- (8) Name or code number of manufacturer
- (9) Name of recipient
- (10) Address of recipient
- (11) Price (cost plus dispensing fee)
- (12) Invoice number/date

d. Home Health Care Services Data

- (1) Case number/SSA number
- (2) Program category
- (3) Agency and person providing service
- (4) Specialization
- (5) Type of treatment/cost or charges
- (6) Name of patient
- (7) Equipment/supplies provided
- (8) Amounts paid
- (9) Invoice number/date

e. Same for Separate Laboratory, X-ray, Clinic and/or Transportation Services

3. DATA RELATING TO ALL TYPES OF PROVIDERS OF SERVICES

a. Practitioners (Doctors - Dentists, etc.)

- (1) Identification number, e.g. narcotic reg. #
- (2) Type of provider
- (3) Name
- (4) Office Address
- (5) License status
- (6) Specialization
- (7) Hospital accreditation
- (8) Treatment activities by:
 - (a) Program categories
 - (b) Case numbers
 - (c) Prescription numbers
 - (d) Visits/type/charges
 - (e) Other services/charges
 - (f) Amounts billed/invoice numbers/dates
 - (g) Payments authorized by Agency or Contractor

b. Pharmacies

- (1) Identification number
- (2) Address
- (3) Name/ownership
- (4) Number of prescriptions filled/weekly/monthly
- (5) Amounts paid/month
- (6) Invoice numbers/dates

c. Facilities (Hospitals, Nursing Homes, Clinics, etc.)

- (1) Identification number
- (2) Facility name/address
- (3) Licensure status/Title XVIII certification
- (4) Capacity/type of structure
- (5) Type of nursing services available
- (6) Type of ownership
- (7) Scope of services available
- (8) Accredited/non-accredited
- (9) Extent of medical records
- (10) Method of computing costs/charges
- (11) Rates of charges
- (12) Kinds/number of personnel
- (13) Safety data
- (14) Beds
 - (a) Types
 - (b) Authorized
 - (c) Occupied
 - (d) Available
- (15) Payments made by Agency or Contractor

4. MEDICAL CARE UTILIZATION DATA

- a. Case numbers w/identification information
- b. Diagnostic studies
 - (1) Dates of each
 - (2) Types/cost/charges
 - (3) Findings
- c. Treatments
 - (1) Dates of each
 - (2) Types/cost or charges
 - (3) Prognosis
- d. Surgical procedures
 - (1) Dates
 - (2) Types/costs or charges
 - (3) Procedure Code
- e. Drugs - types/cost plus Dispensing fees/totals
- f. Hospital days
 - (1) Number paid/cost
 - (2) Number unpaid/cost
 - (3) Number partially paid/cost
- g. Nursing home days
 - (1) Number paid/cost
 - (2) Number unpaid/cost
 - (3) Number partially paid/cost
- h. Utilization Reviews
 - (1) Universe (Total)
 - (2) Number Received
 - (3) Number Cleared
 - (4) Number Referred for Determination
 - (5) Number Disallowed
 - (6) Number continued
 - (7) Direct savings to Program
 - (8) Indirect Saving to Program
- i. Screening Program
 - (1) Number of Routine visit transactions
 - (2) Number of multiphasic visit transactions
 - (3) Number Diagnosed
 - (4) Number referred for treatment
- j. Services Related to Family Planning
(Drugs, Devices, Counselling)

C. SUMMARY REPORTS

- | 1. | <u>Individual
Records</u> | <u>Where
Needed?</u> | <u>What Form of Report</u> | <u>Input Posted</u> |
|----|-------------------------------|--------------------------|----------------------------|---------------------|
| a. | " | State Agency | (Card, Tape, or Disk) | Bi-weekly |
| b. | " | Local Office | (Card, or Print-out) | |
2. Medical Providers Program Data Needed
- | | | | |
|----|---------------------------------|-----------------------|---------|
| a. | Facilities-State Agency
Only | (Card, Tape, or Disk) | Monthly |
| b. | Practitioners | " " " " | " |
| c. | Program
Utilization | " " " " | " |
3. Claims Status
- Number carried over from previous report
 - Number of new claims received
 - Number paid
 - Number pending
4. Family Services
- Visits

ARTICLE V - ADDENDUM 11 - REASONABLE CHARGES

[attach any applicable maximum fee schedule -- must
include the rules for multiple surgery, etc.]

ARTICLE VI - PREPAID CHARGES

1. The single State Agency shall pay to (Blue Cross or Blue Shield) a combined monthly prepaid charge for each Enrolled Recipient certified to the contractor by the single State Agency. Under this contract beginning _____ this prepaid charge shall be \$ _____ for each Enrolled Recipient, to be allocated between Blue Cross and Blue Shield as follows: \$ _____ Blue Cross; \$ _____ Blue Shield.
2. The combined monthly prepaid charges specified in this contract are based on the following benefits and rates:

Inpatient Hospital Services	\$ _____
Outpatient Hospital Services	\$ _____
Skilled Nursing Home Services	\$ _____
Laboratory and X-Ray Services	\$ _____
Home Health Care Services	\$ _____
Screening and Diagnostic Services	\$ _____
for persons under 21 years of age	\$ _____

Physician's Services

Medical Services in hospital	\$ _____
Outpatient services	\$ _____
Home visits	\$ _____
Office visits	\$ _____
Out of hospital laboratory services	\$ _____
Out of hospital X-Ray services	\$ _____
Nursing Home	\$ _____
Total of Physicians Services	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Total of prepaid charges for all benefits \$ _____

3. Because of Contractors professional relations services, which encompasses an extensive management/provider coordination and consultation service capability, the total prepaid charge quoted in paragraph 1 above is an amount that is less than the sum of the charges listed in paragraph 2 for the individual benefits provided. For this reason, should any one of the benefit services listed in the total charge be excluded by the single State Agency, this contract shall be subject to a higher rate of payment for the respective combined prepaid charge.

4. Combined prepaid charges shall be due and payable to Contractor as of the 20th of each month and applicable to Enrolled Recipients having coverage for the following month. If the single State Agency fails to pay the specified monthly charges within _____ days after they become due and payable, this Contract shall be subject to automatic cancellation. No Enrolled Recipient shall, after such cancellation, be entitled to further benefits hereunder, except as provided in _____, but during such period this Contract shall continue in force.
5. In the event this Contract should be cancelled for any reason, the single State Agency shall be liable for all sums due and unpaid, including combined monthly charges for any time this Contract is in force during a grace period.
6. The combined prepaid charges specified in this Article shall remain in effect during the Contract Year. The Contractor shall give the single State Agency written notice not later than _____ that an adjustment in charges for the ensuing Contract Year is or is not required, and if required, the amount thereof. Any such adjustment shall be based upon the experience derived during the current and prior years, future cost trends, the maintenance of prudent reserves in an amount equal to approximately two months combined prepaid charges and such other factors as may be agreed to by the parties. Amounts otherwise payable hereunder and retained by the Contractor pursuant to authorizations for specified deferred payments to physicians for services rendered and covered hereunder shall be considered as payments for purposes of determining experience hereunder.
7. In addition to charges payable pursuant to paragraph 1, on or before the effective date, the State Agency shall pay Blue Cross or Blue Shield the sum of \$ _____ as an initial two month reserve deposit, and to be treated under Article IX as prepaid charges received as follows: \$ _____ Blue Cross; \$ _____ Blue Shield.

ARTICLE VII- GENERAL PROVISIONS

- (a) Statements not Warranties. All statements made by the State Agency or by the individual Subscribers shall be deemed representations and not warranties, and no such statement shall be used in a defense of a claim under this contract, unless it is contained in a written document, a copy of which upon request, shall be furnished to the Claimant.
- (b) Changes in Contract. No agent, person, organization, or association has authority to change this contract or waive any of its provisions. No change in this contract shall be valid unless approved by duly authorized officers of the Contractor and the State Agency evidenced by amendment to this contract of by letter agreement relating thereto.
- (c) Notice of Claim. Written notice of care on which a claim may be based must be given to the Contractor by or on behalf of the subscriber within 30 days after the beginning of such care. Care rendered in a member hospital, or by a physician to whom a Blue Shield Plan makes payment in the regular course of business, shall be deemed written notice under this section.
- (d) Notice to Contractor. Notice given by or on behalf of the subscriber to the Contractor at their address stated in this Contract, or to any authorized agent of the Contractor, with particulars sufficient to identify the subscriber, shall be deemed to be notice to the Contractor. Failure to give notice within the time provided in this contract shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.
- (e) Furnishing Forms. The Contractor, upon receipt of such notice, will furnish or cause to be furnished to the Subscriber such forms as are usually furnished by it for filing proofs of loss. If such forms are not so furnished within 15 days after the receipt of such notice, the subscriber shall be deemed to have complied with the requirements of this contract as to proof of loss upon submitting within the time fixed in this contract for filing proof of loss, written proof covering the occurrence, character, and extent of the care or services for which claim is made.
- (f) Proof of Loss. Affirmative written proof of loss must be furnished to the Contractor not later than December 31st of the calendar year following the one in which the care or service for which benefits are claimed was rendered, except where the employee was legally incapable.
- (g) Payment of Benefits. All benefits provided in this contract will be paid promptly after receipt of the due proof of loss.

- (h) Actions to Recover. No action at law or in equity shall be brought to recover on this contract prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of this contract, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of loss is required by this contract.

ARTICLE VIII - REIMBURSEMENT FOR ADDITIONAL TECHNICAL, PROFESSIONAL
AND ADMINISTRATIVE EXPENSES

In the event additional duties are to be performed by the Contractor pursuant to paragraph A 14 of Article III, it is agreed that the State Agency shall promptly reimburse the Contractor for the services involved on an interim basis of monthly invoices, submitted by the Contractor with final determination at the end of the Contract Year. The determinations shall be based upon Addenda 7 and 8 of Article V.

ARTICLE IX - FINAL ACCOUNTING

Final Accounting of prepaid charges received by the Contractor pursuant to Article VI shall be made by the Contractor in accordance with the provisions of Addendum of Article IX.

ARTICLE IX - ADDENDUM - FINAL ACCOUNTING

1. Not less than 180 days after the end of each Contract Year, the Contractor shall prepare and furnish, to the single State Agency a statement with respect to the operation for that year under the contract. The statement shall be in the form prescribed by the State Agency agreed to by the Contractor and shall include the following items separately as to Blue Cross and Blue Shield:
 - (a) Prepaid charges received and accrued;
 - (b) Payments made and liabilities incurred on behalf of Enrolled Recipients;
 - (c) Other charges composed of --
 - (1) Administrative expenses incurred, _____% of the amount set forth pursuant to subparagraph (a) above.
 - (2) All Taxes incurred.
 - (3) A community support factor _____% of prepaid charges as outlined in 1 (a) above.
 - (4) The amount necessary to satisfy mandatory statutory reserve requirements of the Contractor to the extent that such requirements exceed that portion of the community support factor in (c) (3) above applicable to such Plans.
2.
 - (a) If the amount stated under section 1 (a) exceeds the sum of the amounts stated under sections 1 (b) and 1 (c) the excess shall accrue to a Medicaid Reserve to be held by Blue Cross and Blue Shield in accordance with the provisions of this Article.
 - (b) Blue Cross and Blue Shield shall have available to it all amounts received including those held in the Medicaid Reserve, for payment of obligations incurred.
3. If the sum of the amounts stated under section 1 (a) is less than the sum of the amounts stated under section 1 (b) and 1 (c) the difference shall be recovered from the Medicaid Reserve to the extent of the balance remaining in the Medicaid Reserve. Any remaining difference shall constitute a proper charge against the Medicaid Reserve to be recovered in subsequent contract years.
4. The amount stated under section 1 (b) shall not exclude any payments made or liabilities incurred: (1) as a result of liberalizations made by the State Agency or, (2) in good faith although it subsequently develops that the payment was made for the benefit of an individual who was not entitled thereto.

5. The Contractor shall invest and reinvest all funds in the Medicaid Reserve which in the judgment of the Contractor are in excess of funds needed to discharge promptly the obligations incurred under this contract. Not later than 90 days after the end of each contract year the weighted average rate of income earned (yield) for that year on such investments shall be ascertained and the net income received and accrued from such investments and shall be credited to the Medicaid Reserve.
6. The Contractor shall invest and reinvest all unexpended prepaid charges which in the judgment of the Contractor are in excess of funds needed to discharge promptly the obligations incurred under this contract. Not later than 90 days after the end of each contract year the weighted average rate of income earned (yield) for that year on such investments shall be ascertained and the net income received and accrued from such investments and shall be credited to the State.
7. At the same time the statement required by section 1 is furnished, the Contractor shall furnish the State Agency a memorandum showing, for all contract year, the amounts accruing to or charged against the Medicaid Reserve as a result of each contract year, and the cumulative amounts remaining in or due from the Medicaid Reserve.
8. In the event this contract is discontinued for any reason, and if after the accrued liabilities attributable to this contract plus the administrative expenses determined by agreement of the State Agency and the Contractor as necessary for contract liquidation have been paid and all prepaid charges have been received, there is a balance in the Medicaid Reserve, such balance, including current income derived from investment made under section 5 of this Article, shall be paid to the State Agency within two years from the date this contract is discontinued or within such other period of time as agreed by the Contractor and State Agency.

APPENDIX C

The following are the minimum essential criteria for a Blue Shield utilization review program. Plans are to operate within guidelines established by the NABSP Board of Directors, from which this material is excerpted. Each Plan is given a model program to implement these guidelines, but is encouraged to use its own methods where these are more practical and effective in the Plan's own circumstances.

MINIMUM ESSENTIAL CRITERIA

I. Prevention

A Plan must provide evidence that it has an Information and Education Program on utilization review. The elements of this educational program such as materials, advertisements and meetings must be devised and delivered to physicians, to the public, both enrolled and non-enrolled; and other providers of care, institutions and facilities.

II. Detection

A Plan shall show evidence that it has an integrated ongoing utilization review program. This will be demonstrated by a claims and utilization review system which encompasses the following characteristics:

- A. A routine claims scanning process which assures that complete, accurate, and constant information is supplied on every claim processed;

- B. A routine audit of a random sample of, for example, every 1000th claim;
- C. The compiling of periodic statistical reports which will reflect data on:
 - 1. High usage and dollar volume for both providers and subscribers.
 - 2. High volume procedures by numbers and dollars paid.
 - 3. Overall utilization by type of program (for groups and special programs such as Auto, Steel, Medicare, Medicaid, CHAMPUS, etc.) and by benefit category within each program.
- D. The development of patterns of care, which have been established in cooperation with professional societies, seeing that they are installed and are being utilized in the comparison of daily processed claims data to provide an assessment of quality and quantity of services performed.
- E. Establishment of procedures to investigate all complaints from providers, subscribers, or other persons.

III. Correction

- A Plan shall show evidence of having an established corrective program which includes:
 - A. Procedures for internal staff case review which may include personnel from the secondary claims examiner level to Plan medical advisers.

Appendix C

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- B. Mechanisms for professional review by the various professional groups.
- C. A mechanism through which the decisions of the utilization review committees can be appealed.
- D. Procedures which require a high level of documentation of all utilization review activities. These procedures should be structured to provide a high degree of comparison whether it be individual cases or large statistical studies.

IV. Accountability

A reporting system must be developed which demonstrates the effectiveness of the utilization review program in dollars saved, case trends, and other selected indicators of program effectiveness. These reports will be utilized to inform management and to record information for NABSP. As well, they will be selectively used to inform accounts, governmental agencies, and providers of care.

APPENDIX D
ADDITIONAL COMMENTS ON MATTERS BEFORE
THE COMMITTEE ON WAYS AND MEANS

Mr. Chairman, we are submitting below our comments on other matters before the Committee.

Health Cost Effectiveness Amendments of 1969

We support most of the stated objectives of these amendments. However, it appears to us that the language of the proposed legislation exceeds somewhat the requirements of the objectives.

For example, the Administration seeks broader power to experiment with incentives for economy in the delivery of health services. We interpret the provisions of Paragraph C of Section 402 a.1, as amended, as permitting the use in both Medicare and Medicaid of schedules in effect for programs of entirely different purposes and philosophy. Many of these schedules may be inadequate or outmoded. The possibility of conflict between rising health costs and revenue available for health programs may create a temptation to use the authority conferred by this Paragraph unwisely for the long-range purposes of the program.

Medicare is not a welfare program, nor does the diverse character of its beneficiaries give it any reason to become one. While it may be desirable to seek economical alternatives to the prescribed method of determining a "reasonable charge", payment must remain within the bounds of reasonableness if Medicare patients are to remain an integral part of the patient community, rather than set apart as a special class.

While we endorse the concept of the Secretary's request for authority to discontinue payment to suppliers of services who abuse the program, we note that the proposed Section 5 (g)(1) would prohibit payment to a person where the Secretary finds that that person has submitted an excessive charge for a false statement on a claim. Surely it would be

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better to prohibit payment where the false statement has been made willfully, or when errors do not cease after due warning. We would prefer to see this provision structured to encourage educational activities within the program and improvement in office administration rather than punishment. We think it would do far more for the program in that context.

Blue Shield further recognizes the need and, therefore, supports the objectives contained in Section 5 (g)(4). However, we cannot support the methodology proposed in this Section.

Utilization review is an extremely important element of any health care program, whether it be public or private. The Act itself calls for the design, implementation and administration of a utilization review program as an integral part of a carrier's operations. We compliment Congress for recognizing at the outset the importance of that function. The Congress did not, however, empower the carriers to suspend payments as we do in our private programs should evidence of abuse become available. The proposal is intended to correct this omission and to that extent, we endorse it. But we believe that the processes involving medical review for determination of quality, appropriateness or need should be performed through structures already established by the carriers for their other lines of business. These structures have served the carriers well and in most instances have enabled the carrier to effect correction wherever it has been needed. It is in those few instances in which problems cannot be resolved that we would encourage the Congress to provide the Secretary with authority to suspend further payment. The exercise of this authority need not require a parallel and duplicative medical review structure at the federal level.

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While we can and do support many of the basic principles in the Administration's proposal, we think that it fails to anticipate the legitimate concerns of the providers. We must not lose sight of the fact that Part B of Medicare is an indemnity program. There is no necessary relationship between Medicare's payment and the physician's charge. With the intention of improving the efficiency of the program, our carrier Plans have encouraged physicians to accept assignment. We have had some demonstrable success in this effort. Nevertheless, the physician retains the privilege of divorcing himself from direct involvement in Medicare by refusing to accept an assignment.

Any wholesale reversion to non-assignment can only complicate the program for the patient. It would mean more patients would pay their physicians and wait for reimbursement. It would mean that any failure to reimburse would become a loss to the patient and not to the physician. It would mean more inaccurate claims and more impediments to efficient administration. All of these factors underlie our strong conviction that the language of this bill should be modified in the interests not only of the providers of care, but of the beneficiaries for whom the program is primarily designed.

Chiropractors

We note that there are a number of bills before the Committee which would extend Medicare coverage to the services of chiropractors. We have studied the conclusions of the HEW Task Force which recommended that chiropractic services not be covered. We are in agreement with that conclusion.

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Inclusion of Privately-Practicing Nurse Anesthetists

We recognize the validity of the position that anesthesia carries substantial risks, and should be administered by a physician trained and equipped to deal with adverse results. Nevertheless, there are areas of the country in which qualified anesthesiologists are not routinely available, and where registered nurse anesthetists do serve in the interest of providing the best care available in the circumstances. The patient has little choice in these cases, and tends to be penalized if coverage of anesthesia services -- contemplated by his contract -- is withheld.

Some Blue Shield Plans face this dilemma regularly in their private business. They have found it equitable not to include the services of a privately-practicing nurse-anesthetist as a regular benefit, but to provide payment when the carrier finds administratively -- in the exercise of its judgment -- that this service was dictated by the unavailability of an anesthesiologist and by an intelligent choice from among the available alternatives. We would recommend that the Committee take a similar position, and permit the payment of reasonable charges of privately-practicing nurse-anesthetists where the need for such services can be documented. We would leave the specifics of determining when payment should be made to the administrative judgment of the carrier.

Inclusion of a Drug Benefit

We note that there are several items on the Committee's calendar that would extend Medicare coverage to include prescription drugs. Obviously, drugs are a legitimate part of health care costs, and their

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inclusion would be a valuable addition to the protection afforded by the program.

We have had experience with administration of drug programs. We caution that the special problems created by high claims volume and the technicalities of administering this benefit make it necessary to proceed very carefully in structuring a program. We would like to take this opportunity to offer the help of our staff and that of the Blue Shield Plans should this Committee decide to formulate a drug benefit for Medicare.

Durable Medical Equipment

The Medicare program presently calls for durable medical equipment to be rented or purchased at the beneficiary's option. This provision occasionally results in rental payments considerably exceeding the sum needed to purchase the equipment. Further, it contributes to administrative cost, since rental payments must be serialized and made accessible each month, in order that the carrier may make the necessary periodic payment.

Since the choice of the better option is reasonably related to the length of time the patient will need the equipment, we recommend that the carrier be permitted to exercise the option of rental or purchase on advice of the attending physician, who is frequently able to predict the probable duration of need.

Mr. PARISH. Four attachments.

The CHAIRMAN. Mr. Parish, I had a few questions I wanted to ask of you.

How many States use the model prepaid contract which you and Blue Cross have developed?

Mr. PARISH. At the moment, Mr. Chairman, only one. I think this is largely due to the fact that the contract itself was not distributed until some 4 or 5 months ago.

The CHAIRMAN. Do you mind identifying the State?

Mr. PARISH. No, sir. The State of Montana is using this and has been using it, as a matter of fact, since 1967 when they took the prototype of the contract and put it into effect.

The CHAIRMAN. What would be the advantages of using the model prepaid contract in title XIX?

Mr. PARISH. Well, I would refer first to our testimony, Mr. Chairman, or let me answer it in another way. I indicated that Montana was using the model contract and this program in that State has run extremely well. It has been completely trouble free. All of their clean claims, those that come in without unusual problems have been processed in a cycle time of 3 days. They have had no backlog. There has never been any unfavorable publicity in the State about medicaid, of this program, all of which the plan attributes to the use of the model contract. Of course in the testimony itself we listed a variety of things which would provide better controls of the program, better reporting, not only to the State but to the Federal Government as well.

If there are any specific questions relative to the administration of the program, I would refer them to either of these gentlemen. Mr. Aune represents the Texas plan, which has administered the medicaid program for some time and is fully familiar with the details of it, and how it operates.

The CHAIRMAN. Mr. Parish, what I had in mind was the hope that you might say that through the use of the model prepaid contract we can expect that the medicaid program would cost us less. Is there any evidence to indicate one way or the other the differential in cost through the use of this plan?

Mr. PARISH. I am not sure that it would cost any less, Mr. Chairman, other than the fact that its efficiencies might produce a lower administrative cost, for example.

Also, the use of the utilization review mechanism which is presently in effect for our own private business and for title XVIII would produce, I am sure, a more controlled utilizations and monitoring of costs, and that sort of thing. Actually, it might even cost more in terms of payment for benefits in that I think an improved system would reach more people.

The CHAIRMAN. But not more per person, not more per patient.

Mr. PARISH. No.

The CHAIRMAN. It would cost more because more people would benefit.

Mr. PARISH. It would cost more because more people would utilize the program as a part of a community system which is an operation throughout the entire area.

The CHAIRMAN. It is my recollection that New Mexico had some severe problems in implementing the medicaid program. Was Blue Shield working with the State in any way on medicaid at that time?

Mr. PARISH. Blue Shield was the carrier in the State of New Mexico, yes. I think the problems, as I understand them, and I would refer to one of the other gentlemen who may know more about it, but it is my impression that the concern there was lack of financing rather than any—

The CHAIRMAN. Was it that they started the program broader than their ability to pay?

Mr. PARISH. I believe that is correct.

The CHAIRMAN. I had understood that.

What are the things that Blue Shield's utilization review procedure provides that haven't been done before?

Mr. PARISH. I think the utilization review mechanisms that have been in effect in the past were aimed basically at hospital admissions, hospital days, and use of facilities, whereas with the new standards—and we have had utilization review programs in effect for many years—we are simply sharpening them and making them more effective in an educational sense. These new standards are aimed at a comprehensive review of the utilization of the total spectrum of medical services. Many of the things that have gone into the model utilization review were developed individually by member plans over the years and we have taken the best programs from the various plans and we have translated that into a comprehensive program.

The CHAIRMAN. You use your own utilization review procedure presumably in the case of your own coverage. Are you permitted to use that procedure as a carrier for the social security administration, or do they tell you some other procedure to follow?

Mr. PARISH. No, no. For social security and for title XVIII, yes, we use those procedures.

The CHAIRMAN. Do you use it for both the social security beneficiaries as well as your own—

Mr. PARISH. Private business?

The CHAIRMAN (continuing). Covered insured people.

Mr. PARISH. Yes, sir; but not for the medicaid program.

The CHAIRMAN. You don't use it for medicaid?

Mr. PARISH. That is reserved under the law to the single State agency.

The CHAIRMAN. They do give you some guidelines as to the type of procedures they would like you to use in your utilization review?

Mr. PARISH. You are talking now about the medicaid?

The CHAIRMAN. That is right.

Mr. PARISH. We use it as a support mechanism, but literally the review mechanism is operated by the single State agency.

The CHAIRMAN. Presumably, you have in mind that the procedures that the State would have you use for medicaid do not result in as much preciseness, perhaps, as your own utilization review procedures would bring about, is that right?

Mr. PARISH. That is correct.

The CHAIRMAN. In other words, it costs more to do it the way the States would have you do it than if you were permitted to use the utilization review procedures that you use with respect to your own clientele as well as the clientele of the Social Security Administration?

Mr. PARISH. Again, direct cost is a little difficult to answer in this respect, but it would certainly, we feel, be more efficient, produce a far better program, if we could integrate it into our own system.

The CHAIRMAN. Would the law itself have to be changed and a requirement placed in the law that the States allow you to use these utilization review procedures in order to bring about their use under medicaid, or can the State itself provide for this without us legislating and would it do it if we do not legislate?

Mr. PARISH. It is my understanding that the law would have to be changed.

The CHAIRMAN. It would have to be changed?

Mr. PARISH. Because it currently assigns this responsibility to the State agency, although I think I am correct in stating the State agency can assign its responsibility but it must continue to monitor the program.

The CHAIRMAN. It could do what you are suggesting but it would be better and bring about more certainly if we amend our law?

Mr. PARISH. As you have done, as the Congress did in title XVIII, where this was assigned specifically as a responsibility of the carrier.

The CHAIRMAN. There is not a comparable provision in title XIX and you are suggesting that there should be.

Mr. PARISH. Yes.

The CHAIRMAN. Does Blue Shield feel that coinsurance would have any deterrence to unnecessary utilization review?

Mr. PARISH. Coinsurance is a difficult problem in that if it is in an amount large enough to have a deterring effect on utilization perhaps you run the risk of it keeping people away from these services.

Conversely, if it is too small an item it has no effect on utilization.

The CHAIRMAN. In other words, we can't hope then to strike a medium somewhere along that would make it a deterrent to excessive utilization without depriving people of services that they would actually need? Is that what I am to understand?

Mr. PARISH. You would have to do something of Solomon in this instance, sir. I think the best reliance would be on the educational processes specific to utilization review programs both for the individual and the physician.

The CHAIRMAN. Rather than any change in our law?

Mr. PARISH. Yes, sir.

The CHAIRMAN. Does Blue Shield contract with independent computer firms to do the system designing?

Mr. PARISH. Yes, sir; we do.

The CHAIRMAN. What is the advantage of having an independent computer do this rather than do it yourself?

Mr. PARISH. We have found very significant advantages in this due primarily to the fact that there is a tremendous shortage of talented personnel in the data processing area today. The data processing firms in this business have a variety of challenges, a variety of rewards, that are not available or available to a more limited extent to our own plans. Many of our plans who have turned to outside data processing firms, have succeeded in securing a high degree of capability, the use of much more powerful and sophisticated equipment, than they could afford themselves.

I think perhaps the best example I could give you would be to cite a specific; namely, the California plan, which hired the Electronic Data Systems organization from Texas. The plan, when the EDS went into effect had something in the neighborhood of 650,000 to 675,000 claims backlogged. Within a period of 120 days that claim

load was reduced to something less than 200,000. I understand now it is somewhere in the neighborhood of 125,000, which is probably a little less than normal.

Within our own organization we have established, together with Blue Cross, a project known as UNIT, Uniform National Information Technology, and its main thrust is the development of long-range planning in the data processing area. We launched this project about a year ago, and are making good progress.

We have within our own organization recently gone to the assistance of a plan which was having difficulties similar to those in California. We as a national association together with selected plan personnel literally did a transplant of a system from one plan to another and reduced that plan's backlog in a very short time to a respectable level.

The CHAIRMAN. On page 2 of your statement in the second sentence of the second full paragraph, starting with the word "First", you say, "Blue Shield's techniques include methods other than the customary, prevailing and reasonable mechanism."

That stimulates me to ask you what portion of your total subscribers have contracts under these other techniques?

Mr. PARISH. We have roughly 64 million subscribers under our regular business. I think roughly a third of those are under the usual, customary, so as an off the top of my head figure about two-thirds of our total membership are other than the usual and customary and reasonable approach.

The CHAIRMAN. It is rather widespread then?

Mr. PARISH. Oh, yes; because reasonable and customary is a relatively new approach. Our previous most widely held contracts were under the so-called service benefit programs, with income levels, where fee schedules were used and if the subscriber's income was below a predetermined level then it was paid in full.

The CHAIRMAN. What has been your experience, then, in the use of the other techniques compared to the customary, prevailing and reasonable mechanism? What I am getting at is have your rates gone up there as they have gone up through the use of the customary, prevailing and reasonable mechanism as the social security rate for plan B has gone up or not?

Mr. PARISH. We have increased. First, I understand your question is the relative difference between the cost of a usual and customary program versus some other method?

The CHAIRMAN. That is right.

Mr. PARISH. Where usual and customary has replaced a high-level fee schedule approach the increase in cost has been minimal because the higher level program represented to a large extent the going rates in the area anyhow. Where it replaced a substandard schedule obviously the costs have increased.

As far as total costs are concerned, our actuaries are projecting about a 4- to 4½-percent increase per year in physician fees and 1½ to 2 percent in use of services by our members. Of course these rates have been built into our projections and where we have made commitments to national accounts, for example all of these factors are built into our rates.

Actuaries determine this, and we then guarantee that particular rate for a specific period of time.

The CHAIRMAN. From your own experience is the cost increase in medicare, in medicaid, and in your own business going up about the same, or is there a difference in the three, as to percentage increase in cost?

Mr. PARISH. I would like, if I may, Mr. Chairman, to refer that question to Mr. Aune who has experience in both of these areas and can, I think, speak very specifically to it.

The CHAIRMAN. Also, if you would prefer to supplement your statement by a subsequent statement, I would be glad to have you do that, even.

Yes, Mr. Aune.

Mr. AUNE. I can only talk, of course, for the State of Texas and actually we find that the costs in the three programs, the title XVIII, title XIX, and our own business, are running pretty much in parallel, no significant increases in one area versus other areas.

However, in our particular case in Texas Blue Shield, we are probably some, a little lower in the percent of our private business that is on the usual and customary program, so we are just moving into that area more forcefully and as a result a good share of our business is still on the indemnity fee schedule.

The CHAIRMAN. If you would, Mr. Parish, I would like to have some statements other than just from the State of Texas if you could supply them. What I am getting at is this: I never like to be in the position of having to be the one who says, "I told you so," but when we had our hearings in 1965 preliminary to the enactment of the medicare program, I raised some questions as to the projected costs as set forth by various actuaries. Their projections have turned out to be completely erroneous. The cost of medical care has been rising at the rate of 15 percent, twice as high as income levels have been going up, all during this period since the enactment of the program. Those were things that I suggested might happen that they said could not happen and now they are going beyond 1970 even into 1971, but by 1974 maybe the increase will level off. Maybe it will level off and not be at a rate of 15 percent in 1974 over 1973 even.

Now, I am wondering if in your operations in 1965 when you were making your own estimates of medical cost you were predicting for purposes of your own policy determination the increases that have occurred or were your actuaries also off base at that time?

Mr. PARISH. No, sir: they were relatively accurate. We submitted that information to the Department of Health, Education, and Welfare early in the discussions on the medicare programs and predicted at that time that the rate projections were not adequate. We made that comment to the then Secretary.

If I may add to your earlier question and Mr. Aune's response, the submission of the study which we have made a part of the record here tends to indicate that our regular business and medicaid business has had a reasonably constant percentage of increase and are directly related to each other, and I would add that we will broaden the scope of that study from its present surgical only base to include medical procedures, anesthesiology, radiology, and pathology, all standard areas of medical service. We will make sure that the sample that we produce will be a model of the medical economy of the country and the validity of that will be checked constantly, so we intend to pursue this very assiduously.

The CHAIRMAN. The Senate Finance Committee conducted hearings on July 1 and 2 of this year on medicare and medicaid looking to projections and costs, and things of that sort. On page 29 there is a very interesting chart No. 13, "Physician Fees Have Increased More Rapidly Than the Estimates Assumed." That is the heading of it. I am sure you are familiar with this chart.

Mr. PARISH. I have seen charts of that.

The CHAIRMAN. In 1962 using 1957-59 as 100, physician fees were 112. In 1965, when we enacted the program of medicare they had risen to 121 over the 100 of 1957-59. The projections that were given us in 1965 created a line which was going up but rather constant in this direction. Actually, in 1969, as of the time these hearings occurred, physicians fees were 153 percent or points using the 1957-59 average as 100. That is quite an increase.

It looks to me like in 1970 the projected costs would have gone to about 137 or 138 percent using the 1957-59 average as 100 percent. I don't know what they will be in 1970 but this line is still going up. It is almost straight up on this chart, rather than across and up. I just wondered if your people back then were making the same kinds of projections that the social security people were making as to cost, which certainly is somewhat misleading when one tries to finance a program and I would think would be disastrous with respect to a non-profit organization if your own actuaries had made the same mistake.

Mr. SCHNEEBELI. Mr. Chairman, if you will yield—

The CHAIRMAN. Yes.

Mr. SCHNEEBELI (continuing). During that same period of time the cost of living went up 21 percent.

The CHAIRMAN. That is true, but I am just thinking about our own experience. Was everybody off base about this or were some people right and some people wrong? I don't want to be the only one that was even raising the question. I won't say I was right. I just predicted what was going to happen. It is not just physicians' fees but the same thing is true, of course, for hospital costs and other things. They can be explained and I am not criticizing anybody. It is just that we started a program with an understanding of what the costs were going to be for the next 5, 6, 10 years and it has turned out that every time we look at the fund, we find we are in the red. I am trying to get some hope from somebody that that won't be the case for the next 10 or 15 years.

Mr. PARISH. Mr. Knebel's specific responsibility lies in the area of statistics and research. If I may refer the question.

The CHAIRMAN. Before he starts, in addition, Mr. Parish, if you could for the benefit of this record, let me have from your national organization just what your predictions were nationwide at that time of what the cost would be in 1970, say, compared to the cost that the social security actuaries developed for us in our hearings in 1965, I would appreciate it.

Mr. PARISH. I think we would like to be more specific in this area.

(The information referred to follows:)

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS,
Chicago, Ill., December 16, 1969.

Hon. WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MILLS: In response to your question regarding Blue Shield's actuarial estimates for part B of Medicare, I am submitting below our rating of Part B of H.R. 6675, precisely as it appears on the worksheets of our then actuary, Waldo A. Stevens, dated April 28, 1965.

Calculation A, H.R. 6675

Total program:	<i>Pure premium</i>
1. Basic surgical-medical.....	\$3.38
2. Specialty groups (hospital based).....	0.75
Subtotal	4.13
3. Supplementary:	
A. Home and office visits.....	3.40
B. Diagnostic X-ray and laboratory (out of hospital).....	.50
C. Radium therapy—outpatient.....	.05
D. Surgical dressings, splints, casts, prosthetic devices, braces, artificial arms and legs.....	.30
E. Ambulance services.....	.05
F. Inpatient psychiatric services.....	.50
G. Outpatient psychiatric services.....	.50
H. Home health services.....	.05
Subtotal	5.35
Total, H.R. 6675—no deductible, no copayment.....	9.48

The \$9.48 figure was a pure premium based upon the Blue Shield \$5,000 single/\$7,500 family fee schedules for the Federal Employee Program (full payment for coverage services for people with incomes below these limits.) It was constructed without consideration of administrative expenses and without reference to the \$50 deductible or the 20 percent co-payment period. Two adjustments were then required: 1) to recognize the effect of the deductible, the co-payment and the administrative expenses; and 2) to recognize the effect of converting from an income-limit fee schedule to a program of customary, prevailing and reasonable charges without income limits.

Blue Shield's data permitted the first adjustment, which Mr. Stevens made as follows:

Calculation B—\$50 front-end deductible—80/20 copayment

Total pure premium.....	\$9.48
\$50 front-end deductible.....	-3.00
Total	6.48
80/20 co-payment.....	X .80
Total—(+ 0.92 (expense load) = \$5.64 (rate)).....	5.19

Please note, again, that the \$5.64 projection is based upon use of Blue Shield's \$5,000/\$7,500 programs. Unfortunately, Blue Shield had no national contracts on a customary, prevailing and reasonable charge basis in 1965. We were unable to predict the exact effect of a conversion to customary charges without income limits. However, in a meeting between SSA's actuaries and our own on June 10, 1965 it was agreed that the effect could be significant, and we were aware that in some local conversions of private contracts, the cost had been as high as 28 percent.

Applying such a figure to the \$3.38 component for basic benefits in our \$5.64 overall premium for fee schedule coverage would have raised our estimate for Part B on a customary, prevailing and reasonable charge basis beyond the \$6 rate proposed by H.R. 6675.

However, H.R. 6675 also established an operating reserve of \$18 per beneficiary for Part B. Therefore, our position was that the costs of the program might have been under estimated by a significant margin. But in view of the existence of

an operating reserve—equivalent to one-sixth of premium income for the period July 1, 1966 through December 31, 1967, at which time the premium was to be recalculated—we did not feel that the additional cost would jeopardize the program.

The concept of a cost for converting from one type of contract to the other has since been widely recognized. Its effect has been shown in the conversion of the Federal Employee Program itself. Between 1967 and 1970 about 80 percent of the Blue Shield High-Option subscribers will have shifted from fee schedule coverage to customary, prevailing and reasonable charge coverage. The costs, as submitted to the Civil Service Commission have been as follows:

[In percent]

Year	Cost of conversion to reasonable charges ¹	Cost due to utilization and charge increases	Total increases, except cost of new benefits
1966.....	0.0	4.9	4.9
1967.....	3.7	3.5	7.2
1968.....	10.4	1.5	11.9
1969.....	10.9	3.5	14.4
1970.....	10.1	3.5	13.6

¹ Partial change of coverage in each year, 1967-70.

In answering your question during the hearing, I was also recalling projections for the period 1966-1970 for Part A, offered by the Blue Cross Association. We were aware of these projections. Our actuaries had reviewed them and concurred in them. They appear on pages 192-194 of the Record for your Committee's hearings on H.R. 1 during January and February of 1965.

Again, Mr. Chairman, I want to express our appreciation for the opportunity to appear before your Committee.

Respectfully,

NED F. PARISH,
Executive Vice President.

The CHAIRMAN. I couldn't find anybody at that time that disagreed with them except the actuaries with the insurance companies felt that they were low but I don't remember that they had an exact estimate of how low they were. I am going to ask them to submit for the record their own projections of rising costs in the health field.

Go ahead, please, sir.

Mr. KNEBEL. Mr. Chairman, the gist of the argument put forth by the actuaries at Blue Shield at that time related to the fact that Blue Shield had been trying to serve persons of low income and that we had the cooperation of the physicians in accepting the payments under a fee schedule related to their ability to pay, that the legislation proposed in 1965 and that ultimately became medicare contained no provision for income but did provide for a physician to receive a reasonable charge for his service, and we felt that the impact of changing from a fee schedule geared to ability to pay to one geared to the total population was going to have much more of a cost impact than the actuaries realized at that time.

Our position today is that that did occur, that much of the cost experience by our country and cost trends of physician services relate primarily to this shift from accepting rather modest amounts for persons of low income to a usual charge for all patients.

The CHAIRMAN. The reason I ask all of these questions is that in order to have the errors of our estimates corrected in medicare we

have to either increase the tax from time to time or increase the base of earnings subject to tax.

We have to do one or the other. We have launched the program. We will not repeal it. But we did so on the basis of estimates of cost increases that have been so completely erroneous that we find ourselves now without ability really to limit or determine these increases in rates or in the amounts of earnings subject to tax. We know that they will have to go up. How much over a 25-year period, we just don't know, but we are powerless to stop it unless, of course, we cut back on benefits. Most of the people who appear before the committee are suggesting that we still do not have all of the benefits in the program that should be there. They suggest that one way to cut back here would be to provide for more out-of-hospital medical costs, and I just wonder in the thinking of you gentlemen whether or not that would really cut back in the area of hospitalization, or would it just be an additional expenditure added to an already growing cost of hospitalization and care in hospitals?

Now, if it would cut back the cost of the program that is one thing, but if it is just going to be added on top of our existing costs, it is another thing.

Mr. PARISH. What studies and experience we have had in this area, Mr. Chairman, would indicate the latter, that there is a tendency to add to the cost.

The CHAIRMAN. It would add to the cost?

Mr. PARISH. Yes; it is sort of a Parkinson's law here.

The CHAIRMAN. Just off the record—

(Discussion off the record.)

The CHAIRMAN. As you well know, we wrote in the extended care benefit with the idea that its inclusion in the total package would bring about reduced overall costs in the hospital area through reduced utilization of hospitals. The strange thing is that this extended care benefit has gone up about 10 times what they estimated the cost of it would go up just in this limited period of time. As much as hospital costs have gone up, this part of the program has gone up even faster.

I am trying to find some way, if we can, to prevent any unwarranted increases and then try to hold the costs down as much as we can, and I know that is the goal of the Blue Shield as well as the Blue Cross and all of the other insurance providers.

Do you have any thoughts that you have not expressed in your paper, on or off the record or in executive session, that you could discuss with us, the group of you, Mr. Parish, by yourself, or your organizations, as to how we might handle some of these perplexing problems?

Mr. PARISH. I think we have some ideas.

The CHAIRMAN. Would it be well to discuss them in executive session?

Mr. PARISH. I would think so, sir.

The CHAIRMAN. Would you be prepared to talk to us if we invited you to come in executive session?

Mr. PARISH. We would be delighted to.

The CHAIRMAN. I think it would be better there.

Let me ask you, do you write coverage for people who are on medicare, some type of supplemental policy?

Mr. PARISH. Yes, sir.

The CHAIRMAN. Have your experience with respect to costs in that type of coverage gone up as fast as medicare costs have risen?

Mr. PARISH. I have no national figure on that, Mr. Chairman.

The CHAIRMAN. Would you have one when we get into executive session?

Mr. PARISH. Yes, we could develop that.

The CHAIRMAN. I have been told that your cost of such supplemental coverage has not risen at the same precipitous rate.

Mr. PARISH. If I were required to answer, I think I would be tempted to agree, but we don't have that and we would be very happy to develop it.

The CHAIRMAN. I would like you to have it. Let me ask you this: I have been a pretty strong advocate of a lot of things in my lifetime but nothing that I can recall that I have thought more just or needed than the coverage of the disabled social security beneficiary under the medicare program, or some part of the medicare program. If the Congress should decide to do that, do you have any recommendations as to how we do it? Have you thought about it?

Mr. PARISH. Yes, we have, sir. Our concern here, I expect, would be in the needs of the disabled as opposed to the needs of the aged, for example.

The CHAIRMAN. By needs you mean his medical needs?

Mr. PARISH. Yes, sir; we do cover the disabled in many of our programs. We don't identify them as such, so we don't specifically know the answer to the question, but I would again like to offer our thoughts in this area.

We would be in favor of this, but we would consider it as needing further study to develop what these medical needs are. We might perhaps suggest the possibility of a separate program for them since they might not be able to be melded into existing programs.

The CHAIRMAN. You do take care in your policies of people or at least you offer policies to cover people who are disabled under social security.

Mr. PARISH. Oh, yes.

The CHAIRMAN. Do you give them a different set of medical benefits in that type of policy from those you offer other people who are not disabled?

Mr. PARISH. No. Again, as I say, we don't really identify them as disabled.

The CHAIRMAN. You don't?

Mr. PARISH. If it is a family contract, for example, and there is a child with some disability, whether it be physical or mental disability, they are not singled out and identified as such.

The CHAIRMAN. But your thought is that they might need less hospitalization and more of something else.

Mr. PARISH. We really don't know, but we are reasonably sure that they are probably different. The needs are probably different.

The CHAIRMAN. I wonder about the numbers of these people that are covered. I understand the health insurance premium is high for the family of a disabled person under social security, that if the only income that that family has is based upon social security benefits it is very difficult for them to find the means to own the policy. Is that not true?

Mr. PARISH. Yes.

The CHAIRMAN. Do they have any difficulty actually in qualifying for such a medical policy? They have been adjudicated as being 100-percent disabled.

Mr. PARISH. Well, under the family example, the disabled child, of the family is not removed from that contract at a given age limit as he would be if he were normal. As long as that dependency remains, the child stays on that contract at the family rate. He is not set aside as an individual subscriber.

The CHAIRMAN. We are told and have been told all along that the person over 65 in all probability will require more hospital days for the same illness than one much younger than 65 would require. Is it true that the disabled may require as much as twice the hospitalization days of the nondisabled?

We have been told that.

Mr. PARISH. Mr. Aune has indicated some experience in this area, especially title XIX, if he may respond to that.

Mr. AUNE. Under our title XIX program, we have found that the permanently and totally disabled have required substantially greater care than people in comparable age groups.

The CHAIRMAN. Not only the number of days with respect to illness A, but they are likely to have illness B or C, much more frequently.

Is that your point?

Mr. AUNE. Yes, sir.

The CHAIRMAN. They will require, then, probably twice as much hospitalization?

Mr. AUNE. Twice as much hospitalization and related services. Indicative of this, I believe, is that in 1967 Texas liberalized its definition of "permanently and totally disabled" to bring it in more harmony with the Federal definition for title XIX purposes. This doubled our APTD rolls and very, very sharply increased the utilization of the title XIX services in this area and, in fact, led to the rates being slightly more than doubled in the 2-year period because of these people coming on the rolls.

The CHAIRMAN. Let me change the subject matter and ask you my final question, Mr. Parish. Would you favor putting in a fee schedule for medicare, not medicaid, which is similar to or at least based upon your own fee schedules?

Mr. PARISH. No, sir; I don't think we would. The law, as we interpreted it, indicated that these people would be moved into the mainstream of medical care. There is a very definite trend toward the paid in full, usual and customary approach in our regular business. Fee schedules, I expect, will always remain with us, but will become in our judgment at least the minority aspect of our business, and we would prefer to see the concept of the usual, customary paid-in-full approach subjected to proper monitoring controls, utilization reviews, and so forth.

The CHAIRMAN. Thank you. Thank you very much.

Mr. Schneebeli?

Mr. SCHNEEBELI. Mr. Parish, I was interested in your statement on page 3, that you conclude that there was no particular difference between the charge levels allowed for medicare and for private enrollment and the same as for medicaid. We have seen some rather

sensational allegations that the medical profession is taking advantage of medicare and medicaid and charging considerably more through these two areas of approach as compared to the regular private charges. You say here you have had over 41,000 samples that you have reviewed. This is a pretty broad survey, isn't it, and your conclusions certainly differ from these allegations.

Mr. PARISH. That is correct, sir.

Mr. SCHNEEBELI. Then you discount them and you think they are terribly wrong, these allegations?

Mr. PARISH. Absolutely no question that there have been abuses of the program. This is pretty obvious.

Mr. SCHNEEBELI. There have been what?

Mr. PARISH. There have been abuses of the program by individual physicians. There is no question about this. But we in judging the mass of the cases that we have looked at find no significant difference between the payments made to physicians under the Government programs and under our private business.

Mr. SCHNEEBELI. Well, in order to make the medicaid and medicare programs look as though they are properly supervised, don't you think we should give the proper public relations effect to this study that you have made? I haven't seen any statements challenging these rather sensational allegations and I think it would be entirely proper. Is this the first time that your statement has been publicized or made, or have you tried to refute some of the allegations previously?

Mr. PARISH. This is the first time that a national study has been made. I think perhaps the best example I could quote otherwise would be the widespread publicity given to the *Polansky* case in the State of Michigan and as you have undoubtedly read, that audit has been completed and not only were his charges substantiated, but many of them could have been considerably higher had the doctor chosen to follow that route.

Mr. SCHNEEBELI. I think there have been some intimations made that in New York City, too, there are a lot of instances where the audit shows a great amount of improper payments.

Would you say it is less than 5 percent or less than 2 percent of the cases?

Mr. PARISH. I would hesitate to quote a percentage, but, in our judgment, it is minor. These are the so-called horror cases that we are all familiar with and they make excellent reading.

Mr. SCHNEEBELI. To what degree have the local medical associations tried to police this differential, this difference in charges? Are the local county medical associations assuming any responsibility in this area?

Mr. PARISH. Indeed they are, sir. Our experience in every State throughout the country, indicates very active review committees.

Each Blue Shield plan has an active professional relations department which is constantly in communication with doctors all over its area on an educational basis and they have established these review committees throughout the medical community.

Mr. SCHNEEBELI. How do these review agencies that you have perform their work? Do they go directly to the county medical associations or the State medical associations?

Mr. PARISH. It will vary according to the case.

Mr. SCHNEEBELI. And they have been very effective in the instances that you have been able to correct a lot of the abuses that originally came up?

Mr. PARISH. We feel very successful; yes, sir.

Mr. SCHNEEBELI. And you feel you have been successful in eliminating so many of these?

Mr. PARISH. And will improve as our ability to develop the material for these committees to look at improves.

Mr. SCHNEEBELI. I would like to see widespread publicity given to not only the results of your survey but the effort you are making in trying to eliminate these abuses because I think it is very important in the public mind at the outset of a program that has such broad ramifications that the public accept it as being properly handled, and apparently you are concerned and doing something about the problem and I would like to see the proper publicity given to it because, as you might well imagine, we as members of the committee receive a lot of these complaints. I think you can eliminate a lot of these complaints if you have broader distribution of your publicity on what you have found and what you are doing.

Mr. PARISH. Thank you, sir.

Mr. SCHNEEBELI. I think it is quite important.

The CHAIRMAN. Any further questions?

Mr. Burke?

Mr. BURKE. I had some questions along the line that Mr. Schneebeli has asked, but I will skip those and I would like to go to this "ability to pay" principle and how that works out as far as medicare is concerned. What is the quality of care given medicare patients in comparison with private patients?

Mr. PARISH. Quality of care, sir? I don't think there is any difference between the quality of care rendered simply because of the fact that they are covered under a private or a public program. I am sure that the physicians of this country are dedicated to the welfare of the patient and curing whatever is wrong with him. I believe that there isn't any substandard care involved.

Mr. BURKE. On page 1 of your exhibit A in your last two paragraphs you say this:

Many recipients of charity medicine intuitively believed that the care which they received was of lower quality than that received by noncharity patients.

What is the attitude of the hospitals and the doctors toward medicare and medicaid patients? Do they look upon them as charity cases? Do they look upon them as people who are in there for service, whose costs are being paid for?

Mr. PARISH. We find no evidence of anything other than what I said before, they are patients, period, in need of care and that care is rendered.

Mr. BURKE. In your second paragraph you say that—

Some observers have suggested that providers of health services receive higher payments from prepayment agencies for services rendered to patients being covered by Government financed programs for similar services performed for private contract patients.

What is that?

Mr. PARISH. I am sorry, I am not staying with you.

Mr. BURKE. That is in your appendix A, first page.

Mr. PARISH. A comparison of the Government and non-Government?

Mr. BURKE. Yes. I would like to have your observations on that. Is this true?

Mr. PARISH. The paragraph beginning "Rather than constructing"?

Mr. BURKE. The Government is paying higher for the services than similar services performed for private contract patients. To your knowledge, is that true?

Mr. PARISH. I am still lost.

Mr. BURKE. I am merely taking it from your appendix.

Mr. PARISH. Yes. I am trying to follow the question, sir. I am sorry. I am a little too thick this morning, I guess.

Mr. BURKE. Second paragraph. It expresses the concern of those directly involved with the health care delivery system and what some believe to be payment disparities. Some observers have suggested that providers of health services receive higher payments from prepayment agencies for services rendered to patients covered by Government financed programs than for similar services performed for private contract patients.

Would you care to make an observation on that?

Mr. PARISH. Mr. Knebel has found this. I still haven't.

Mr. KNEBEL. This was the premise from which our researchers began their study. It was that there had been allegations that providers were receiving more funds from these prepayment organizations in the Government arena than they were from the same organizations with their private subscribers.

Mr. BURKE. I am not going to ask you who made these allegations, but are they from responsible people, Government agency people or State agency people?

Mr. KNEBEL. The primary sources that I am personally familiar with have come from study groups, task forces, that feel this is happening.

Mr. BURKE. How do you feel about it?

Mr. KNEBEL. We wanted the study undertaken. This is the study, the report on that study, in which we tested these procedures and we have concluded that that is certainly not the case, at least in our Blue Shield programs, where they are serving as carriers for the Government.

Mr. BURKE. Where a worker is covered under a fee schedule Blue Shield plan the physician gets less than for medicare patient. Is that correct?

Mr. KNEBEL. Some physicians, sir. The fee schedule should be equated to pay all physicians about the average and under the medicare the physicians below the average should only be permitted to collect their usual fee and not as much as the average.

Mr. BURKE. Do you think that is a good public policy?

Mr. KNEBEL. The average?

Mr. BURKE. Where the worker is covered under a fee schedule Blue Shield plan and the physician gets less than for a medicare patient. Is that a good public policy?

Mr. KNEBEL. Well, sir, in the Blue Shield—

Mr. BURKE. Maybe you would like to answer a lot of these questions in executive session. I don't want to go too deeply into it. I know it is a sensitive subject, but it is a matter of concern.

The CHAIRMAN. Would you yield, Mr. Burke?

Mr. BURKE. Yes, Mr. Chairman.

The CHAIRMAN. I think what Mr. Burke is getting at is this: Under the medicare program you have paid what is average and customary but under some of your own policies you paid the fee that is normally charged by that particular physician, though you may be above the average that we pay or you may be below it, depending upon what the physician actually charges. Is that the situation?

Mr. PARISH. The chances are that we would be above it on any usual and customary program because of the fee containment of the former Secretary of Health, Education, and Welfare's promulgation of a rate which stopped the level at something—

The CHAIRMAN. Your fees generally that you pay on your policies compared to the medicare application are higher, are they not?

Mr. PARISH. If they are in the usual, customary, and reasonable concept, yes. If they are a fee schedule it could be all over the lot, Mr. Burke. It could be higher or lower. It depends. There are a variety of levels of fee schedules sold by the various plans that could represent a considerably lower amount or actually could pay higher.

Mr. BURKE. I understand that in one State the Blue Shield plan pays \$75 for an eye operation. Medicaid pays an average of \$336. Is that correct?

Mr. PARISH. I haven't any idea. I presume that if that is the case that is a very low level indemnity type of coverage offered by that plan and that would be a matter of payment rather than of charge in the first place. If the only thing that the schedule called for was the payment of \$75 and the physician's regular on-going charge was \$300, the other \$225 has got to come out of the patient's pocket.

Mr. BURKE. In other words, this indemnity plan only covers \$75 for the payment.

Mr. PARISH. This could be and without knowing the plan I couldn't obviously, comment. It may have a whole variety of schedules that go from that very low level to a very high level.

Mr. BURKE. On your consumer price index here I notice in 1961 this medical care. Is that the hospital care that you refer to in this chart? You have three lines here, one All Items, one Physicians Fees, and the other Medical Care.

Mr. PARISH. This is Mr. Knebel's area.

Mr. KNEBEL. No, that is not simply hospital care. That is the combined index for all medical care services and they have drawn also a line that was pertaining solely to physicians fees. Had they included as they should have, a line for hospital care, it would have been an additional line on this that would have been substantially higher.

Mr. BURKE. I notice in this index that the physicians fees ran along up to about 1966 slightly behind other costs and then they apparently passed them and they joined together and are apparently going hand in hand with the rise in cost. Have you any information on the part of the doctors or on the part of the hospitals that there are any plans afoot for the leveling off of these costs or do they expect this pyramiding of costs to continue?

Mr. PARISH. What studies we have in the cost area, and I cannot comment on hospital care, and I am sure you have that figure—

Mr. BURKE. I thought you might have access to some information whereby the AMA and the American Hospital Association might be

taking some kind of steps to level off this pyramiding rise. Are they doing anything that you know of to try to level off these costs or are they just allowing them to continue to rise?

Mr. PARISH. Well, I cannot speak for other organizations. Our own studies indicated earlier that our actuaries are projecting a cost increase in fees of approximately 4½ percent, which is about a half a percent under the current Consumer Price Index.

Mr. BURKE. You say hold them down to 4½ percent?

Mr. PARISH. This is our projection of what will happen. I am only talking about physician costs, not hospital costs or any other type of cost but this is what we read from what has occurred to this date and what we are projecting for future years that this will be, purely in the cost element now. It has nothing to do with increased use of services or increased benefits which might be added, but I am speaking specifically of physician costs which we anticipate will increase at about that rate annually.

Mr. BURKE. What about hospital costs?

Mr. PARISH. I am not prepared to comment on that. I think the Blue Cross Association has made specific comments on that, Mr. Mills.

The CHAIRMAN. Off the record.

(Discussion off the record.)

Mr. BURKE. Thank you very much.

The CHAIRMAN. Any further questions of these very fine witnesses? We do thank you so much. You have been very helpful to us.

Mr. PARISH. Thank you, sir.

The CHAIRMAN. We will get in touch with you. Thank you very much.

Mr. PARISH. Thank you, sir.

The CHAIRMAN. Mr. Miller and the American Pharmaceutical Association representatives.

Mr. Miller, if you will identify yourself for our record and those at the table with you, we will be glad to recognize you.

STATEMENT OF JACOB W. MILLER, CHAIRMAN, COMMITTEE ON PUBLIC AFFAIRS, AMERICAN PHARMACEUTICAL ASSOCIATION; ACCOMPANIED BY ROGER W. CAIN, ASSISTANT EXECUTIVE DIRECTOR FOR ASSOCIATION AFFAIRS; AND CARL ROBERTS, DIRECTOR, LEGAL DIVISION

Mr. MILLER. Mr. Chairman, I am Jacob W. Miller, chairman of the American Pharmaceutical Association's Committee on Public Affairs.

The American Pharmaceutical Association is the national professional society of pharmacists. Its approximately 50,000 members are composed of practicing pharmacists, pharmaceutical educators, pharmaceutical scientists, and pharmacy students.

I am a practicing community pharmacist in Topeka, Kans., and president-elect of the Kansas Pharmaceutical Association. I am also an attorney and serve as a pharmacy consultant to the Kansas Department of Social Welfare and the Kansas Department of Health, as well as Kansas Blue Cross/Blue Shield. My consulting activities are concentrated primarily on the medicare-medicaid and State welfare pharmacy programs.

I am accompanied by Mr. Carl Roberts, director of the APHA Legal Division, and Mr. Roger W. Cain, assistant executive director for association affairs.

The CHAIRMAN. We are pleased to have you, Mr. Miller, and Mr. Roberts, and Mr. Cain, with us. You are recognized, sir.

Mr. MILLER. Thank you, sir.

SUMMARY

1. Many pharmacists are being solicited for "kickbacks" by small hospitals, nursing homes and extended care facilities.

2. The "kickback" problem can be reduced by: 1) basing reimbursement for pharmaceutical services on the cost of drug dispensed plus a usual and customary professional fee for the pharmacist's services; 2) by ensuring that reimbursement is made directly to the pharmacist by the responsible agency.

Mr. Chairman, pharmacists provide pharmaceutical services in a number of health care programs financed wholly or in part of the Federal Government, particularly under medicaid and medicare. We know that the success of these programs is largely dependent upon the Government's ability to maintain them under sound fiscal controls.

The title XIX medicaid program has already been imperiled by runaway costs resulting in emergency Federal legislation to ease the financial impact of the program on the several States. This experience has illustrated dramatically the necessity for procedures which will keep program costs within projected and authorized limits.

Mr. Chairman, we are here this morning to bring to the attention of this committee a problem facing pharmacists which places them in an untenable ethical and legal position. We also hope to offer possible solutions to the problem. I refer to instances in which pharmacists are subjected to demands for "kickbacks" to small hospitals, nursing homes, and extended care facilities whose operations are supported directly or indirectly by Federal funds.

The CHAIRMAN. Let me interrupt you. We are very much interested in this. We are going to follow you with a great deal of care.

Mr. MILLER. All right, sir.

As I am sure you are aware, many health care facilities do not maintain their own onsite pharmaceutical services. Rather, they look to the community pharmacist to provide such service on a contract basis. Naturally, in most situations, there is competition among pharmacists for such practice. Many pharmacists have been unable to obtain these contracts without being solicited for under-the-table payments.

Needless to say, such payments are absolutely unethical from a professional standpoint. Section 5 of the APHA code of ethics provides:

A pharmacist should seek at all times only fair and reasonable remuneration for his services. He should never agree to, or participate in transactions with practitioners of other health professions or any other person under which fees are divided or which may cause financial or other exploitation in connection with the rendering of his professional services.

Moreover, those who participate in such schemes aid and abet the recipient in submitting false statements to the Federal Government, thus violating Federal criminal statutes. In *U.S. v. Thompson*, 366 F. 2d 167 (1966), a "kickback" arrangement on a federally financed construction project was held a criminal conspiracy against the United States. Also, in many States these activities violate commercial bribery or other criminal statutes.

Unfortunately, the existence of potential criminal and professional sanctions has not been sufficient to prevent either the demand for illegal payments or accession to these demands by some pharmacists.

The problem with regard to nursing homes in Michigan was apparently so great that it caused the enactment of a law requiring licensing of nursing-home administrators and providing for suspension or revocation of license for seeking a "kickback" from pharmacists or other suppliers.

We believe this continuing problem is not attributable to the inadequacy of existing laws, but rather primarily to the practical problems involved in their enforcement. We know, for example, that the Social Security Administration has been greatly concerned about this problem. But with limited manpower, even working through State agencies and other fiscal intermediaries, enforcement efforts have been difficult.

Moreover, there is apparently some difficulty in obtaining criminal prosecutions by the Department of Justice in cases which may be uncovered. This is not difficult to understand, when the relatively small monetary amounts involved in these situations are compared to those in major fraud cases prosecuted by the Department of Justice. What is needed, in our view, are new approaches to eliminating or at least reducing the problem without the necessity of depending on criminal-law enforcement. We will suggest two such approaches in a moment.

Before proceeding, Mr. Chairman, we wish to make clear that we are not objecting to or discussing situations in which legitimate discounts are granted hospitals, nursing homes, and extended-care facilities by pharmacists. Present HEW regulations recognize such discounts and provide for their accountability by the institutional provider of service.

Simply stated, all such discounts must be used to reduce the provider's costs and, therefore, must accrue ultimately to the benefit of the Government. However, where discounts have been used as a competitive device by pharmacists to obtain institutional practice, benefits to the Government frequently have been illusory.

We know that some pharmacists who purport to grant discounts to obtain nursing-home practice have simply inflated their charges so that their net financial position does not change. Any discount is a discount, in fact, only if the charge being discounted is fixed and ascertainable. To the extent pharmacists may use a flexible system for pricing their services or drugs they dispense, the system is open to abuse.

At present, approximately 12.5 million prescriptions per year are dispensed to nursing-home and extend-care facility in-patients. It is virtually impossible for the Government to monitor and audit the reasonableness of charges for this volume of prescriptions.

On the other hand, there are only approximately 52,000 pharmacies in this country. We believe that to remedy the situation there should be a general Federal requirement that compensation for pharmaceutical services have two components: (1) reimbursement for the cost of the drug, and (2) a specific professional fee for the pharmacist's services.

The pharmacist would be required to certify to the Government that the fee ultimately charged the Government is no greater than the usual and customary fee he charges other parties for the same services. It would be relatively simple to monitor fees based on this method. Cost parameters for drug products could also be established with relative ease. Both items of information are adaptable to computer use,

and thus can be utilized to reduce substantially the administrative burdens connected with these programs.

The Kansas Pharmaceutical Association, in cooperation with University of Kansas personnel and the Kansas Department of Social Welfare, have devised a new method of reimbursement for pharmaceutical services in the Kansas Medicaid program.

APHA believes this unique and workable method will equitably and responsibly serve all drug-insurance programs whether Government-sponsored, as under title XIX or the envisioned out-of-hospital prescription benefits under title XVIII, or private insurance programs.

The HEW Task Force on Prescription Drugs has stated, in essence, that a prescription-drug insurance program should provide for reimbursement of product cost and, in addition, should allow reimbursement of overhead expenses incurred in dispensing the drug product as well as reasonable profit for the pharmacist.

The Kansas Board of Social Welfare, in implementing its title XIX program in 1967, had already committed itself to payment of usual and customary fees, if reasonable, for medical services provided to eligible recipients. While usual, reasonable and customary fee structures were known or ascertainable in other areas of medical services, the Kansas Department of Social Welfare found itself unable to adopt the method of reimbursing pharmacists at their usual and customary rates because there was no basis for determining the reasonableness of any individual charge. Because of competitive factors, including anti-trust prohibitions, pharmacists were unable even to discuss, much less to standardize, their charges for individual prescriptions.

Hence, for the 7 years which have ensued since Kansas first adopted a uniform welfare drug program, reimbursement for pharmaceutical services has been based on a State-imposed percentage markup method, which bears only occasional relationship to usual and customary charges and no relationship at all to reasonableness from the standpoint of either the pharmacist who provides the service or the State which pays for the service.

Although a flat statewide fee, based upon averages, can be easily administered by a fiscal agent, it may be inequitable because of variables in the number of prescriptions dispensed, overhead expenses, and other economic factors. At present, some pharmacies actually subsidize welfare prescription programs at the expense of the general public.

Under our Kansas program, the pharmacist is asked to determine his average gross income per prescription. He may do this by taking a statistically accurate sampling of prescriptions actually dispensed during the sampling period. The pharmacist determines the total charges for those prescriptions included in the sample and deducts the total net acquisition cost of the drug products dispensed in those prescriptions. The resulting gross income for the sample, when divided by the number of prescriptions sampled, provides an average gross income or average professional fee per prescription. This fee—an individualized pharmacy usual and customary dispensing fee—can be easily determined, and when added to the acquisition cost of the drug product dispensed will yield the average usual and customary charge of the pharmacy.

To ensure that the usual and customary fee as determined above is reasonable and equitable to all parties involved, it is necessary to deter-

mine what portion of the fee is attributable to overhead and what portion represents return on capital and educational investment. To accomplish this, APHA and many professors of pharmacy administration have devised several methods, based on sound accounting principles, for determining an individual pharmacy's cost of dispensing a prescription, using the pharmacy's readily available information.

Mr. Chairman, we would like to briefly outline the principles of the new reimbursement method developed in Kansas. This method goes far in providing each pharmacist reasonable reimbursement, while simultaneously providing Government simplified preaudit fiscal controls rather than expensive postaudits which are ineffective in controlling costs.

All pharmacies participating in the Kansas plan will be required to file their average usual and customary fee with the State Welfare Department. The fees will then be ranked from lowest to highest. The highest 10 percent will be reduced automatically to the 90th percentile, and no fee paid will exceed this 90-percentile amount.

Pharmacies submitting fees falling between the 50th and 90th percentile will be required to submit financial data to justify the fee filed. All fees thus substantiated will be honored. Fees falling between the 50th and 1st percentile will be honored without the necessity of further substantiation, unless the pharmacy is within the top 20 percent in welfare prescription volume in the State. If the pharmacy is within this group, its fee must be justified no matter what the amount. Any pharmacy which does not submit a fee will automatically be assigned the lowest fee requested. Fees may be resubmitted annually or when in the judgment of the department of social welfare reevaluation is necessary.

We believe that the Kansas plan is equitable to all parties involved, and we recommend that it receive the consideration of this committee as it studies improvements in the medicare-medicaid programs.

Mr. Chairman, earlier we commented on the "kickback" situation. We believe they cannot be entirely eliminated so long as pharmacists compete to serve small hospitals, nursing homes, and extended-care facilities. However, we believe medicare and medicaid programs encourage the demand and receipt of illegal payments from pharmacists because their reimbursement is funneled through these facilities. We believe that the kickback problem can be controlled further by adding pharmacists to the present list of providers of service under part A of medicare and also when out-of-hospital drugs are added to that program. Also, all payments for pharmaceutical services under medicaid should be required to be made directly to the pharmacist.

We are greatly disturbed that the kickback situation we have described exists. Public opinion condemns all such breaches of public trust. However, the most bitter complaints we have received are from pharmacists who have, in fact, been subjected to kickback demands. By far the vast majority of the Nation's pharmacists conduct themselves with both legal and ethical propriety. Unfortunately, there are some who fail to measure up to their obligations.

With assistance from those creating and administering Federal programs, we believe that pharmacy can eliminate this unfair competitive practice and devote its best efforts to the primary objective of these programs, providing pharmaceutical services at reasonable cost for persons in need of them.

The CHAIRMAN. We thank you very much, Mr. Miller, for your very fine statement. We appreciate your bringing with you Mr. Cain and Mr. Roberts.

Let me ask you, is this a typical kickback arrangement? Let me see if I understand.

A pharmacist will rent a storage room or some space in a nursing home or in an extended-care facility. The rent will be very high, and it will be related directly to the amount of pharmacy business generated.

Mr. MILLER. This is one method, sir.

The CHAIRMAN. What are some other methods?

Mr. MILLER. Another method would be for all prescriptions for patients or residents of the nursing home to be filled in the off-premise location of the pharmacy, billed then to the nursing home, and then a percentage of the total billing kicked back to the nursing home.

The CHAIRMAN. An actual kickback of 10 percent or some such figure?

Mr. MILLER. Yes, sir.

The CHAIRMAN. You mean they are as brazen as to do that?

Mr. MILLER. Yes, sir. This is not to condemn the normal simplified billing procedure, where a collection fee is paid, a discount off of the total bill.

The CHAIRMAN. It is in addition to any kind of discount that is normally provided?

Mr. MILLER. Right; in some instances the billing might go in from the pharmacy with a 10-percent volume discount, which would show on the billing. But what we are talking about is the under-the-table reimbursement.

The CHAIRMAN. Is this very widespread in your opinion?

Mr. MILLER. There is a great deal of it, sir.

The CHAIRMAN. Mr. Schneebeli?

Mr. SCHNEEBELI. Mr. Miller, I think you have given us a very responsible statement here and something actually that concerns the committee. Have any other States adopted the Kansas approach?

Mr. MILLER. No, sir. This is unique. It is newly developed. It is not yet in practice.

Mr. SCHNEEBELI. How long has your plan been in practice?

Mr. MILLER. We have had welfare programs first under Kerr-Mills and then under title XIX for 7 years.

Mr. SCHNEEBELI. Hasn't your plan been in effect for 7 years?

Mr. MILLER. No, we have had this markup system where a percentage markup is paid. We are going to the system that I described today on July 1.

Mr. SCHNEEBELI. You just have done so in Kansas?

Mr. MILLER. We are in the process of gathering data.

Mr. SCHNEEBELI. Have any other States indicated an interest in following your proposal?

Mr. MILLER. There is a lot of interest shown throughout the Nation in this program, sir.

Mr. SCHNEEBELI. I can see where there would be a lot of interest shown by the members of the committee, too. I judge that your Kansas plan has been endorsed by the national association by the presence of these two gentlemen with you.

Mr. ROBERTS. Yes, sir, most certainly it has.

Mr. SCHNEEBELI. The national association endorses this approach?

Mr. ROBERTS. It most certainly does.

Mr. SCHNEEBELI. How much do you think it will cut down on the cost of prescriptions for medicaid in the event this were made national?

Mr. MILLER. Because we have had no experience in this area yet, sir, I can only give my own personal observations of the situation in Kansas. And we feel that tying the fee paid to the overhead of an individual store will result in substantial savings, because we feel that the bulk of welfare prescriptions are filled in stores where overhead is in fact low, so that there should be a lowered cost to the department of social welfare for this program.

In any instance, there will be an equitable payment made.

Mr. SCHNEEBELI. I would like to congratulate you and your association in this very strenuous and obvious effort to police your association and your whole profession in this area.

Mr. MILLER. Thank you, sir.

Mr. SCHNEEBELI. Certainly you are going to eliminate a lot of bad publicity in the future.

Thank you very much.

The CHAIRMAN. Mr. Conable.

Mr. CONABLE. Mr. Chairman, thank you.

Does implementation of the Kansas plan require a great deal more accounting than pharmacists normally use?

Mr. MILLER. No, sir.

Mr. CONABLE. I understand the devices you have in here to require minimal records in the event that the fees charged by the pharmacists are below the 50-percent level, and do you find that that operates to mitigate the burden of accounting that otherwise would be there?

Mr. MILLER. It helps, sir.

Mr. CONABLE. It helps the small pharmacist, doesn't it?

Mr. MILLER. Right.

Mr. CONABLE. We impose really tremendous cost-accounting burdens on nursing homes, for instance, that participate in medicare. Apparently it would not be the same onerous burden for pharmacists to follow the proposal that you have. Is that correct?

Mr. MILLER. No, sir. We conducted a study last year of the cost of filling a prescription, and we got a 16-percent return strictly on a voluntary basis, 16 percent of the State's pharmacists submitted this data, and it is data that is available from their income tax returns, sir.

Mr. CONABLE. Generally speaking, are pharmacists who participate in these public programs required to adopt very substantial additional burdens beyond an ordinary private pharmacy that doesn't participate? I am concerned, for instance, with respect to nursing homes that we have a comparatively modest part of the actual patient load of the nursing home covered by the public programs. Yet we require a high degree of cost accounting, for instance, and the result is that we wind up substantially increasing the costs for those who aren't participating in the public programs.

Is that not a problem with respect to pharmacies generally?

Mr. MILLER. I would like for Mr. Cain to answer that question.

Mr. CAIN. The actual standards for pharmaceutical services in extended-care facilities as promulgated by the Social Security Administration are higher standards than we had——

Mr. CONABLE. Are they financially burdensome?

Mr. CAIN (continuing). Prior to the program. They are not financially costly. They are the kind of standards that we have always needed for small hospitals and for extended-care facilities, and they are only equivalent to the standards that we have in the large hospitals.

Mr. CONABLE. So you don't feel the result has been inevitably to increase drug costs to everyone?

Mr. CAIN. No, we do not.

Mr. CONABLE. Thank you, Mr. Chairman.

The CHAIRMAN. We do appreciate very much your coming to the committee.

I wish you would do this. I would like you to stimulate some of these pharmacists, without identifying themselves if they would prefer not to identify themselves, to give us some examples of what they have experienced in the way of requirements by nursing homes, hospitals, extended-care facilities, whatever it is, for some type of kickback on the bill.

Mr. MILLER. We will be glad to do that.

The CHAIRMAN. Thank you again for coming to the committee.

Mr. MILLER. Thank you, sir.

(The following was received by the committee:)

AMERICAN PHARMACEUTICAL ASSOCIATION,
Washington, D.C., November 18, 1969.

Mr. JOHN M. MARTIN, Jr.,
Chief Counsel, Committee on Ways and Means, Longworth House Office Building,
Washington, D.C.

DEAR MR. MARTIN: On behalf of Jacob W. Miller, Chairman of the American Pharmaceutical Association's Committee on Public Affairs, I am returning herewith the corrected transcript of the Association's testimony presented on Monday, November 10.

In the November 15th APhA Newsletter, APhA is encouraging pharmacists to bring to the attention of the Committee actual "kickback" situations in which they may have been personally involved. This, of course, is in response to the request made by Chairman Mills during our appearance.

Having reviewed the testimony, we believe there is one additional point which should be brought to the attention of the Committee. Congressman Conable expressed concern about bookkeeping and accounting procedures required of pharmacists under Medicare and Medicaid. He was told that these were not overly burdensome, at least in so far as the Kansas Plan for pharmacist reimbursement is concerned.

The additional point we wish to make is that pharmacists are concerned about the total administrative claims burden which will be imposed on them not only under Medicare-Medicaid, but also under other third-party payment programs. The present multiplicity of claim forms, identification cards, card imprinters, and other administrative requirements pose a substantial problem for pharmacists. Unless this problem is resolved by a reasonable degree of standardization of administrative procedures, it will ultimately act to increase the cost of drugs to the public.

Through the National Pharmacy Insurance Council, recently organized and sponsored by APhA, we are attempting to bring about this necessary administrative standardization. Naturally, these efforts must be carried on within the present limits established by the antitrust laws. We wish to assure the Committee that our efforts along these lines are intended to keep the cost of drugs under these programs within reasonable and responsible limits.

We would appreciate having this letter appended to our testimony for the record.

Sincerely,

CARL ROBERTS,
Director, Legal Division.

[From the APhA Newsletter, Nov. 15, 1969]

APHA SUGGEST METHODS TO END "KICKBACKS"; MILLS SEEKS REPORTS

APhA has suggested methods to the U.S. Congress for reducing demands upon pharmacists for "kickbacks" by small hospitals, nursing homes and extended care facilities using government health care program funds.

The proposals were made Nov. 10 when three APhA officials appeared before the House of Representatives' Committee on Ways and Means chaired by Rep. Wilbur D. Mills (D-Ark). Testifying were Jacob W. Miller, Chairman of the APhA Policy Committee on Public Affairs, APhA Legal Division Director Carl Roberts, and APhA Assistant Executive Director for Association Affairs Roger W. Cain.

At the conclusion of the testimony, Chairman Mills thanked the witnesses for their "very fine statement" and asked APhA to urge pharmacists to let the Ways and Means Committee know how they have been affected by "kickback" demands. He said the information could be anonymous or by name. Contact: Rep. Wilbur D. Mills, House of Representatives, Washington, D.C. 20515.

Committee member Rep. H. T. Schneebeli (R-Pa.) also stated: "I would like to congratulate you and your Association in this very strenuous and obvious effort to police your Association and your whole profession in this area."

Mr. Miller is a community pharmacist from Topeka, Kan., and President-elect of the Kansas Pharmaceutical Association. Mr. Miller, who is also an attorney, serves as a pharmacy consultant to Kansas health and welfare departments and the Kansas Blue Cross/Blue Shield.

Mr. Miller said the "kickback" problem can be reduced by: 1. basing reimbursement for pharmaceutical services on the cost of the drug dispensed plus a usual and customary professional fee for the pharmacist's services; 2. by ensuring that reimbursement is made directly to the pharmacist by the responsible agency.

Portions of the testimony follow:

"Pharmacists provide pharmaceutical services in a number of health care programs financed wholly or in part by the Federal government, and particularly under Medicaid and Medicare. We know that the success of these programs is largely dependent upon government's ability to maintain them under sound fiscal controls. The Title XIX Medicaid program has already been imperiled by runaway costs resulting in emergency Federal legislation to ease the financial impact of the program on the several states. This experience has illustrated dramatically the necessity for procedures which will keep program costs within projected and authorized limits.

"Mr. Chairman, we are here to bring to the attention of this Committee a problem facing pharmacists which places them in an untenable ethical and legal position. We also hope to offer possible solutions to the problem. I refer to instances in which pharmacists are subjected to demands for 'kickbacks' to small hospitals, nursing homes, and extended care facilities whose operations are supporting directly or indirectly by Federal funds.

"As I am sure you are aware, many health care facilities do not maintain their own on-side pharmaceutical services. Rather, they look to the community pharmacist to provide such service on a contract basis. Naturally, in most situations, there is competition among pharmacists for such practice. Many pharmacists have been unable to obtain these contracts without being solicited for 'under-the-table' payments.

"Needless to say, such payments are absolutely unethical from a professional standpoint, [as stated in] Section 5 of the APhA Code of Ethics. Moreover, those who participate in such schemes aid and abet the recipient in submitting false statements to the Federal government, thus violating Federal criminal statutes.

"Unfortunately, the existence of potential criminal and professional sanctions has not been sufficient to prevent either the demand for illegal payments or accession to these demands by some pharmacists. The problem with regard to nursing homes in Michigan was apparently so great that it caused the enactment of a law requiring licensing of nursing home administrators and providing for suspension or revocation of license for seeking a 'kickback' from pharmacists or other suppliers.

"We believe this continuing problem is not attributable to the inadequacy of existing laws, but rather primarily to the practical problems involved in their enforcement. We know, for example, that the Social Security Administration has been greatly concerned about this problem, but with limited manpower,

even working through state agencies and other fiscal intermediaries, enforcement efforts have been difficult.

"Moreover, there is apparently some difficulty in obtaining criminal prosecutions by the Department of Justice in cases which may be uncovered. This is not difficult to understand, when the relatively small monetary amounts involved in these situations are compared to those in major fraud cases prosecuted by the Department of Justice. What is needed, in our view, are new approaches to eliminating or, at least, reducing the problem without the necessity of depending on criminal law enforcement.

"We wish to make clear that we are not objecting to, or discussing situations in which legitimate discounts are granted hospitals, nursing homes and extended care facilities by pharmacists. Present HEW regulations recognize such discounts and provide for their accountability by the institutional provider of service.

"Simply stated, all such discounts must be used to reduce the provider's costs and, therefore, must accrue ultimately to the benefit of the government. However, where discounts have been used as a competitive device by pharmacists to obtain institutional practice, benefits to the government frequently have been illusory. We know that some pharmacists who purport to grant discounts to obtain nursing home practice have simply inflated their charges so that their net financial position does not change. Any discount is a discount in fact only if the charge being discounted is fixed and ascertainable. To the extent pharmacists may use a flexible system for pricing their services or drugs they dispense, the system is open to abuse.

"At present, approximately 12.5 million prescriptions per year are dispensed to nursing home and extended care facility 'in-patients'. It is virtually impossible for the government to monitor and audit the reasonableness of charges for this volume of prescriptions. On the other hand, there are only approximately 52,000 pharmacists in this country.

"We believe that to remedy the situation there should be a general Federal requirement that compensation for pharmaceutical services have two components: (1) reimbursement for the cost of the drug; and (2) a specific professional fee for the pharmacist's services. The pharmacist would be required to certify to the government that the fee ultimately charged the government is no greater than the usual and customary fee he charges other parties for the same services.

"It would be relatively simple to monitor fees based on this method. Cost parameters for drug products could also be established with relative ease. Both items of information are adaptable to computer use, and thus can be utilized to reduce substantially the administrative burdens connected with these programs."

The CHAIRMAN. Mr. Cunningham.

Mr. Cunningham, if you will identify yourself for our record, we will be glad to recognize you, sir.

STATEMENT OF C. ROSS CUNNINGHAM, MANAGER, WASHINGTON OFFICE, CHRISTIAN SCIENTISTS IN THE UNITED STATES AND FIRST CHURCH OF CHRIST, SCIENTIST

Mr. CUNNINGHAM. Fine. My name is C. Ross Cunningham, and I am manager of the Washington, D.C., office of the Christian Science Committee on Publication. As such, I represent all the Christian Science Churches and Christian Scientists in the United States. I would like to discuss with you briefly how the medicare and medicaid programs have been functioning in their relation to benefits for Christian Scientists and to make some suggestions to protect the religious rights of persons who do not prefer to use medical treatment for healing.

As you know, Christian Scientists rely exclusively on spiritual means through prayer for the prevention and cure of disease. At the same time, we do not oppose any health programs applied to the medically oriented majority of the population. In fact, we applaud the motives

of all who sincerely seek to conquer the human problems associated with disease, poverty, and age.

However, when a Christian Scientist becomes sick, he turns to a Christian Science practitioner for help through prayer instead of a physician. If nursing assistance is needed, he will seek out a Christian Science nurse. If institutional care is required, he will go to a Christian Science sanatorium.

The medicare and medicaid programs both include provision for payment of services in Christian Science sanatoriums, and under current regulations a State may include the services of Christian Science visiting nurses in their title XIX plans.

On the whole, the medicare and medicaid programs have run smoothly for most Christian Science sanatoriums, but there are some statutory problems which are potentially serious to us and to the programs.

The cost of services provided under medicare in Christian Science sanatoriums is a small fraction of total disbursements under title XVIII, and our title XIX benefits are smaller yet. In part, costs are so low because Christian Scientists do not go to a sanatorium unless it is absolutely necessary and unless the case is so serious that care in the home is not practicable. Also, the form of care provided, being non-medical, does not involve expensive equipment, drugs, and personnel.

CHRISTIAN SCIENCE SANATORIUMS AND MEDICAID

Under section 1905(a) (15) of the Social Security Act and related regulations, States may include Christian Science sanatoriums in their title XIX plans. Like all institutions, these sanatoriums are required to be subject to State standard-setting authority by section 1902 (a) (9). We do not think it proper to have States set standards for the care of patients in Christian Science facilities. We are glad, even anxious, to have States prescribe minimum levels for safety and sanitation and to inspect our buildings regularly from these standpoints. It must be understood, however, that Christian Science treatment is quite basically different from medical treatment and cannot be measured by medical criteria. Moreover, the States do not seem to wish to get involved in examining a kind of care which is meaningful only as an auxiliary to religious healing.

The Christian Science Church has an administrative division called the department of care, which sets standards for our institutions, accredits them, and inspects them frequently. It trains and accredits Christian Science nurses and sets nurse-patient ratios and other professional standards for the sanatoriums which compare favorably with standards set for medical nursing homes.

In recognition of the peculiar situation States would face in trying to set standards for the care of patients who are institutionalized while seeking religious healing, we have drafted an amendment to section 1902(a) (9) of the Social Security Act. We suggest the following language:

Amend section 1902(a) (9) by inserting after "services" the following:

except, however, that a sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Mass., shall not be required to be subject to state standards for patient care and services.

LICENSING OF CHRISTIAN SCIENCE SANATORIUM ADMINISTRATORS

As you know, the Social Security Amendments of 1967 contained a new requirement that every State with an approved plan under title XIX must license all nursing home administrators. The rule applies to the administrators of all facilities defined as "nursing homes" under State law, including those which are not participating in the medicaid program. The States are now in the process of setting up nursing home administrator licensing requirements, which, in many cases, include course work in principles of medical care, psychology, pharmacology, et cetera. License applicants will be examined on such matters as anatomy and physiology, materia medica, the aging process, and the administration of drugs. A Christian Scientist would have deep and grave misgivings of conscience about involving himself in such matters. If he refused to take the courses or tests and the present nursing home administrator statute were enforced, either the Christian Science sanatorium he administered would be forced to close or Federal medicaid funds to the State would be cut off. This would be true even if the sanatorium had no relationship to medicare or medicaid.

The Department of Care of the Christian Science Church has established its own requirements for approval of an administrator of a Christian Science sanatorium, and they are very high. Administrators are required to take university-level courses in management practices, accounting, et cetera, and to be knowledgeable about methods of Christian Science nursing.

We do not believe the Federal Government should compel the States to license the directors of this unique type of institution, and we do not think Congress ever intended that administrators of nonmedical facilities should be required to demonstrate proficiency in medical subjects. Accordingly, we have drafted an amendment to the Social Security Act designed to meet the unique problems of these religiously oriented homes. It would amend section 1908(g) (1) to read:

(1) "Nursing home" means any institution or facility, except a sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Mass., defined as such for licensing purposes under State law, or, if State law does not employ the term "nursing home," the equivalent term or terms as determined by the Secretary; and

To assist your committee in its drafting, we offer some alternative language which would combine the two above-suggested changes into one brief sentence to be added to section 1907 as a new subsection, as follows:

Amend section 1907 by inserting "(a)" before "Nothing" and adding at the end the following:

(b) For purposes of this title, a sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Mass., shall not be deemed to be a nursing home, and shall not be required to be subject to State standards for patient care and services.

This wording would have the advantage of simplicity and would combine all the religious matters in title XIX in one place.

HEALTH COST EFFECTIVENESS AMENDMENTS OF 1969

The administration proposes to make medicare reimbursement based on expenditures for plant and equipment conditional on conformity

of those expenditures with an overall State plan developed under the partnership for health amendments. Any new or expanded health-care facility which does not comply with the plan will not be allowed to consider depreciation of the plant as an element of reasonable cost to the extent of unplanned expenditures.

This seems a reasonable approach to controlling excessive or overlapping expansion, but it would not work for Christian Science sanatoriums, because the legislation establishing comprehensive health planning did not embrace these facilities.

The House report on the bill creating the planning program states:

* * * a facility such as those provided by the Christian Science Church, relying solely on spiritual means through prayer for healing, would not be included as a health-care facility within the meaning of this program.

(H. Rept. 538, 90th Cong., p. 21.) Thus, our institutions are in the anomalous situation of being excluded from State planning, but included in the medicare program. We believe that the rationale which led Congress to leave these sanatoriums out of State planning programs should extend to excluding them from any penalty for not complying with State plans. As a practical matter, States do not want to establish plans for facilities for those who rely on prayer for healing and would not have the background to do so.

Furthermore, the types of expensive equipment and overexpanded plants, which are the subject of much of the criticized spending in hospitals, do not exist in Christian Science sanatoriums. Accordingly, we are suggesting that an amendment be made to the health cost effectiveness amendments along the following lines:

The provisions of this paragraph shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Mass.

OBSERVANCE OF RELIGIOUS BELIEFS

Several titles of the Social Security Act contain provisions for medical benefits to be dispensed by State agencies. Neither Congress nor the Department of Health, Education, and Welfare has ever suggested that eligible persons should be compelled to accept these benefits. They are simply made available to those who want them. However, it has been our experience that when sweeping and intensive programs are authorized by Federal law they are treated at the local level as compulsory.

In recognition of the right of those with religious objections to decline these health services, Congress added sections 515 and 1907 to the Social Security Act. These two sections apply to the maternal and child welfare, title V, and medicaid, title XIX, programs. Now we note that title IV of the act is to be greatly expanded.

Although there are few medically directed provisions in this title, it appears to be the probable destination of a vastly expanded day-care program with broad supportive services. Christian Scientists would feel much freer to participate in the new family-assistance plan if they felt sure that any related medical services could be declined.

Accordingly, we offer the following amendment to title IV to make clear that the Federal Government does not require the States to make medical services mandatory:

In H.R. 14173, on page 34, after line 4, add:

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 465. Nothing in this title shall be construed to require any State which has any plan or program approved under, or receiving financial support under, this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or service provided under such plan or program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

In closing let us thank you for the consideration this committee has always given us as well as for this opportunity to testify. The main thing to remember is that we seek these legislative changes, not to advance our denomination, but to maintain a sense of impartiality between two healing systems, one of which is founded on religious belief. We believe that the suggestions made in this statement can only improve the programs they are addressed to, and will not weaken them in any way.

(The summary of the foregoing statement follows:)

SUMMARY OF STATEMENT OF THE CHRISTIAN SCIENCE CHURCH

The Christian Science Church :

1. Believes that on the whole the Medicare and Medicaid programs are operating reasonably well to meet the institutional and nursing needs of the Christian Scientists who qualify for these benefits.

2. Favors specific exemption of Christian Science sanatoriums from the requirement of State standards of patient care in Title XIX.

3. Requests that States be permitted to exempt Christian Science sanatoriums from the administrator licensing requirement of section 1908.

4. Asks that institutions not deemed to be health care facilities for the purposes of the State health planning provision of the Public Health Service Act, be permitted to receive depreciation payments under Medicare.

5. Proposes that all medical benefits under Title IV of the Social Security Act be provided on a purely voluntary basis.

The CHAIRMAN. Thank you so much for bringing your statement to the committee.

Mr. CUNNINGHAM. Thank you.

The CHAIRMAN. Any questions of Mr. Cunningham?

If not, we thank you very much.

Mr. CUNNINGHAM. Thank you.

The CHAIRMAN. Dr. Turchin?

Dr. Turchin, if you will identify yourself for our record by giving us your name, address, and capacity in which you appear, we will be glad to recognize you.

**STATEMENT OF DR. CHARLES R. TURCHIN, PRESIDENT, AMERICAN
PODIATRY ASSOCIATION; ACCOMPANIED BY DR. SEWARD P.
NYMAN, EXECUTIVE DIRECTOR; AND JOHN R. CARSON, DIREC-
TOR, GOVERNMENTAL AFFAIRS DEPARTMENT**

Dr. TURCHIN. Mr. Chairman and members of the committee, before presenting my brief statement, I would like to introduce the two gentlemen with me. On my left is Dr. Seward P. Nyman, executive director of the American Podiatry Association; on my right is Mr. John R. Carson, director of the governmental affairs department of our association.

I am Dr. Charles R. Turchin, president of the American Podiatry Association and a practicing podiatrist in the District of Columbia.

The American Podiatry Association, whose membership I represent here today, is a voluntary, nonprofit organization, established in 1912 and composed of 53 component societies—one in each State, the District of Columbia, Puerto Rico, and a society for podiatrists in Federal service.

In the Social Security Amendments of 1965 and 1967, the Federal Government took significant steps to provide needed health services for disadvantaged citizens and those of retirement age. Though services have increased during the last 4 years, questions of program efficiency and quality care remain as overriding national concerns.

In connection with program efficiency, the American Podiatry Association recognized the need for cooperation with administrators as early as 1960. Since that time, podiatry peer review committees have been working with carriers representing public and private insurance programs to insure that beneficiaries are receiving quality care at a reasonable cost.

The American Podiatry Association supported and continues to support the principles embodied in medicare and medicaid. The association also recognizes the necessity for revisions in the law which will hasten the attainment of an essential national goal—comprehensive quality health care for all citizens regardless of economic status.

Medicare and medicaid represent important first steps in the attainment of this national goal. Four years of experience have provided invaluable lessons in the operation of major public health insurance and assistance programs. In reviewing these programs, we must make a concerted effort to deal with the deficiencies of both medicare and medicaid.

Recognizing the committee's desire to conserve time and to avoid repetitious testimony, I will concentrate on those program areas which require remedial action to provide quality foot care to beneficiaries of medicare and medicaid.

MEDICARE—DEFICIENCIES AND RECOMMENDATIONS

The enactment of Public Law 90-248 added podiatrists' services to the health benefits available to beneficiaries under medicare. However, experiences to date have exposed certain inadequacies in the provisions and administration of foot-care services under medicare. Our recommendations to improve these services are as follows:

Section 1862 of the Social Security Act lists the services which are excluded from coverage under the medicare program. However, podiatrists' experiences have clearly demonstrated that present exclusions pertaining to foot care are neither conducive to controlling costs nor assuring that only necessary foot care will be furnished under the program.

Instead of considering the treatment of the foot on the same basis as other parts of the body, section 1862—paragraph 13—employs language which even 2 years after enactment defies clear interpretation. As a result, much time and effort is being devoted by the Social Security Administration in seeking the correct application of this paragraph to specific problem areas, and we are still awaiting decisions on several important questions of interpretation.

It is our recommendation that the medicare program, like other health insurance plans, provide for complete medical and surgical care of the foot, as is the case for other parts of the body.

A conforming amendment to title XVIII, section 1861(b)(4), is required to bring podiatric inpatient hospital services in line with other physicians' services. This section enables a hospital under part A to be reimbursed for the reasonable costs of the services of interns and residents in an approved teaching program. However, section 1861, which identifies the various accrediting agencies that approve such programs, inadvertently omits the Council on Education of the American Podiatry Association. This oversight should now be corrected.

The association's council on education, recognized by the U.S. Office of Education and the National Commission on Accrediting as the national accrediting agency for podiatric education programs, should be specifically included in section 1861(b)(4) of the act.

MEDICAID—DEFICIENCIES AND RECOMMENDATIONS

Podiatrists, who now participate in 33 of the 44 approved State title XIX programs, are concerned about the lack of coordination between the medicare and medicaid programs. I refer specifically to the lack of uniformity in the act's definition and interpretation of the term "physician."

Section 1861(r) of the act includes the podiatrist under the term "physician" for the purposes of title XVIII. Title XIX, on the other hand, does not define the term "physician." Instead, the meaning of the term has been left to administrative interpretation. The result has been to exclude the podiatrist from the meaning of "physician" for title XIX. This particular lack of consistency has produced serious problems for podiatrists, carriers, administrators, and—more importantly—the program's beneficiaries.

A specific example of this problem is the medicare "buy in" arrangement, in which more than 40 States participate. These States, by paying the medicare part B charges, qualify the elderly poor for medicare benefits, including podiatrists' services which are defined as physicians' services under title XVIII.

Yet in many of these same States, medicaid beneficiaries under 65 are denied a podiatrist's services.

It is recommended that this inconsistent application of the law be remedied by amending title XIX for the purpose of defining the term "physician," including within such definition the podiatrist.

SUMMARY

Mr. Chairman, we commend your committee for undertaking a massive but essential task. Each of us realizes that the achievement of national health goals will not be easily or quickly accomplished. Yet it is imperative that the Nation build responsibly on an already impressive record by promptly remedying medicare and medicaid's inadequacies, including those in the area of foot care. This can best be done by:

(1) Amending section 1862 of the act to provide for complete medical and surgical care of the foot, as is the case for other parts of the body.

(2) Amending section 1861(b)(4) of the act to identify the association's council on education as the national accrediting agency for podiatric education programs.

(3) Amending title XIX of the act for the purpose of providing a definition of "physician" which would include the podiatrist.

In closing, I would like to emphasize the importance of providing quality foot care for the senior citizens of this country. We must assure, as a minimum, that the next generation of older Americans does not have the same high incidence of foot problems that podiatrists are now treating as part of their participation in the medicare program. And one of the best ways to achieve this goal is to make available to older people services which will prevent many foot conditions before they occur. These services are not now available under medicare because of a belief that the cost of providing them might be excessive.

But, as one health administrator recently pointed out, "There is a catch to the philosophy of 'cut services and save'; and the catch is that the services you eliminate or fail to provide may be replaced by the ones you keep at a greater expense." And he gave this example: "An ingrown toenail that a podiatrist could have repaired in his office may progress until the patient must be admitted to the hospital for surgery."

Mr. Chairman, thank you for your courtesy in inviting us to present this testimony. We look forward to cooperating with you, with this committee and the Congress in providing improved health care for all Americans.

And, of course, we would be glad to answer any questions that the committee may have.

The CHAIRMAN. We thank you, Dr. Turchin, for bringing to the committee the views of the American Podiatry Association.

Any questions?

We thank you very much.

Dr. TURCHIN. Thank you.

The CHAIRMAN. Mr. Noland. Mr. Noland, before you identify yourself, our colleague on the committee, Dick Fulton from Tennessee, wanted me to express his regret that he was unable to be here today to hear your testimony. He has told me that his good friend J. Howard Edmondson, whom you know, presumably, had spoken to him about what an effective job you are doing. And he wanted to be here personally to greet you, but due to matters beyond his control he is out of the city today.

So if you will identify yourself for our record, we will be glad to recognize you, sir.

**STATEMENT OF ROYCE P. NOLAND, EXECUTIVE DIRECTOR,
AMERICAN PHYSICAL THERAPY ASSOCIATION; ACCOMPANIED
BY CLEM EISCHEN**

Mr. NOLAND. Thank you, Chairman Mills and members of the committee, my name is Royce Noland, and I am the executive director of the American Physical Therapy Association. With me today is Mr. Clem Eischen, a practicing physical therapist from Portland, Oreg.

The American Physical Therapy Association represents over 14,000 qualified physical therapists in the United States. This constitutes

well over 80 percent of the physical therapists in the country. There are 51 schools of physical therapy accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association. Licensing acts prevail in 49 States to govern qualifications and standards and scope of practice.

The American Physical Therapy Association has been an active participant in advocating legislation and consulting on regulations for the purpose of advancing the availability of quality health care through comprehensive health-care programs.

In a program of health care services such as that provided by the Social Security Act, simple allusion to high quality comprehensive health care is insufficient, and the promotion of this concept alone represents inadequate participation by any health profession or its representative association. Neither is it adequate that the administrators of the program should see as the singular goal to merely arrange financial details, spend allotments, and reimburse vendors. If optimums are to be reached, then there must be a collaboration between the Government agencies and the health professions so that continuous attention can be given to how the money is used and with what effects.

We would like to present some proposals for amendments to the Social Security Act that we feel will enhance the program and reduce costs. I would first relate our reasons for these proposals.

Every effort should be made to obtain as much effective health care as is possible from the resources that are available.

The American Physical Therapy Association has presented testimony before this committee and other committees concerned with the Social Security Act and other health related legislation. In our previous testimony we have attempted to lend our qualified counsel that is inherent in our accrued experience dealing with a single component of the total health care system. A responsible health association, however, must also take cognizance of how their specialized service relates to the total health care system, and it is incumbent on such an association to relay recommendations in that sphere.

We have tried in previous testimony to lend this kind of counsel and to alert those in Government, both in the legislative and administrative branches, of what we have felt were legitimate concerns and bring to the attention of the administrators of the program those items that, from our experience, could impede or hamper the quality and effectiveness of the program. We do not note with pleasure that our concerns and our predicted pitfalls of the program have proven to be accurate. We prefer to look back only to gain the benefit of experience so that we all might look forward. With 3 years of experience under the existing structure of the medicare system and a similar 3 years of field experience lends both the Government and our association an opportunity for valid appraisal.

From the inception of the Social Security Amendments of 1965, physical therapy has been identified as one of the services available, but only as these services related to those furnished by a provider of service. In the amendments of 1967 an attempt was made to broaden the base of facilities that could provide the services of physical therapy. The authors of those new sections, which created some new categories of providers for the specific purpose of providing physical

therapy service, should be commended for their sincere effort. It is regrettable that attempts at implementation of these categories have proven relatively unsuccessful. The reasons for this are twofold:

(1) Most of the agencies eligible for these new categories were already eligible to be providers under the original provision of the act.

(2) The regulations developed by Health, Education, and Welfare were so cumbersome and self-limiting that it has made it virtually impossible for any existing health facility that was not already a hospital, extended care facility, or home health agency to become qualified. This was not because they lacked the capacity to provide high quality care, nor was it because they lacked the capacity to be a participant in a comprehensive program of health care. It is simply a matter that the legislation as it was developed and the regulations as they evolved established barriers to facilities that might want to participate. These barriers were not relevant or meaningful to quality of service of facilities, but dealt more with administrative procedural matters.

Thus, at this time, the situation still exists that only certain providers have available physical therapy services. At the same time there exists a significant group of physical therapists who have equal qualifications to those rendering service under a provider and have facilities that are equal or exceed those of most providers. This latter group is not able to render service under the program.

One of the rationales used for this situation is that the thrust of the program is to encourage high quality comprehensive health care, that is, the integrated action of several health professions serving the multiple needs of the patient. This association strongly supports this concept. We take exception to the assumption that to cause a health professional to participate in an integrated comprehensive program, the participating health professional must be economically tied to the facility or agency.

There is considerable history to support our position. There are many Government-sponsored health insurance programs that have long existed prior to the medicare program that have effectively used physical therapists not identified with any particular institution or agency. Included in this are the crippled children's programs and the Veterans' Administration's hometown care program.

As a matter of fact, the medicare program is the only third-party-payer program sponsored by the Federal Government that does not make use of qualified physical therapists who do not happen to be situated within the confines of an institution or agency. These physical therapists are equally qualified to those institutionally based and perform their services under the same system of medical direction and referral. They are licensed under the same practice acts, and, as members of the American Physical Therapy Association, are bound by the same code of ethics.

The cost of physical therapy services as now provided in the act has been of great concern to this association. We have seen the costs to the Government for physical-therapy services skyrocket way beyond that which would normally be expected even in our present inflationary spiral. This can easily be accounted to the administrative system that is used for reimbursement for physical therapy under the program.

Parallels can be drawn with other programs. An ideal illustration is the contrast between the cost for physical-therapy services provided

for a person in an extended-care facility under medicare and then the same service being provided for a person under medicaid. I am sure it is recognized by the committee that many eligible beneficiaries of medicare are dual-qualified. Therefore, the illustrative case could actually be in reference to one person. Differentials of as much as \$22 have been identified. That is, a physical-therapy service rendered in an extended-care facility provided by the extended-care facility or through arrangement with a home-health agency, have been claimed at as high as \$30 for a single visit. The same service provided by a physical therapist making claim under the medicaid program, where direct billing by a physical therapist is (in some States) possible, is at a maximum rate of \$9.20, and even this amount reduces for subsequent visits.

In each instance the same service is provided by persons equally qualified under the laws of the respective State and by the personnel standards established by medicare. The services are under the same institutional regulations and the same procedures for recordkeeping. Integrated action between multiple health services is utilized equally, and the same medical referral mechanism is used. The services are subject to the same kinds of utilization review.

Although the case in point is used as an illustration, actual case histories substantiating this very illustration are multiple. The difference is, of course, that in the case of medicare only the institution is the responsible fiscal party. In the medicaid program the physical therapist is the accountable party. He reports directly to the intermediary, he is identified with the care given, he is identified with the amount of care given for the total program and with the individual patients to whom he renders service. The American Physical Therapy Association is profoundly concerned that such incongruous dual situations can exist and are frustrated by the fact that because of the administrative procedures under medicare our abilities to effectively alter this pattern are impaired.

We recognize that there may indeed have been service provided in the past that was outside of the intended scope of service and exceeded reasonable community standards for frequency or nature of the service. But we are powerless to take voluntary action when, in fact, the physical therapist is not the responsible party.

We concur in the concept of limitations on scope of service, on maintaining high standards on qualifications for physical therapists to participate, and limiting reimbursement to services that have a reasonable chance of demonstrating achievement of medically sound improvement in the health status of the patient. We also subscribe to the concept that optimum health care is best served by coordinated health-care plans and programs.

It is for these foregoing reasons that we urge the Committee on Ways and Means to take under advisement changes in the Social Security Act that will: (1) improve the utilization of physical therapists, (2) increase the reasonable control over quality of care, (3) enhance the comprehensive coordinated aspect of care, and (4) do these at reasonable cost to the Government.

Our tentative proposal for amendment is as follows:

Amend section 1861(s) (2) by adding paragraph (E).

(E) Direct physical therapy services:

Add to section 1861 (p) a separate section, to wit :

The term "direct physical therapy services" means professional physical-therapy services performed by a physical therapist to an individual—

- (1) who is under the care of a physician, and
- (2) with respect to whom a plan prescribing the type, amount and duration of physical-therapy services that are to be furnished such individual has been established, and is periodically reviewed, by a physician, and

- (3) only if performed by a physical therapist who—

(A) is licensed or registered in the state (if such licensing exists in the state),

(B) has other qualifications equal to those established in regulations for physical therapists rendering service for a provider of service,

(C) maintains clinical records on all patients and submits such reports of progress and otherwise as is deemed necessary and appropriate by the prescribing physician to any provider of service concurrently or subsequently rendering care to the patient,

(D) when rendering service at a facility (other than a provider of service), maintains such facility in accordance with standards for physical facilities equal to those established for providers of service as they apply to being adequate to provide physical-therapy care,

(E) is participating in a program of utilization review in accordance with procedures established by the Secretary and approved by the state agency,

(F) agrees to a level of payment as being payment in full that does not exceed such payment ordinarily received for such services in accordance with community standards and usual and prevailing schedules of payment,

(G) meets such other requirements and participates under such conditions relating to the health and safety of individuals as the Secretary may find necessary,

excluding, however—

- (4) any item or service if it would not be included under subsection (b) if subsection (b) if furnished to an in-patient of a hospital.

This proposal represents the most stringent and moral limitations for any service under the program of any that I have been able to identify under the law. Yet they allow for optimum use of the manpower facilities available.

For this reason we urge their consideration.

The CHAIRMAN. Does that complete your statement, Mr. Noland?

Mr. NOLAND. Yes, sir.

The CHAIRMAN. We thank you very much for your statement and bringing to us the views you have expressed.

Any questions?

Mr. Corman.

Mr. CORMAN. Thank you, Mr. Chairman.

Mr. Noland, do I understand the normal procedure is that the medical doctor prescribes the therapy a person is to receive and then the physical therapist who is licensed carries that out under the direction of the doctor? I don't mean that the doctor is there, but the doctor prescribes what type of therapy he is going to get and the physical therapist merely carries it out.

Mr. NOLAND. That is correct, sir.

Mr. CORMAN. Who decides if a patient is probably going to improve from this therapy? The reason for my question is that I have had some complaints from therapists in California that a doctor may prescribe physical therapy and it is rendered by the physical therapist. Then someone in the intermediary decides that that category of case is not properly subject to physical therapy, and therefore they deny the payment.

Are you aware of this?

Mr. NOLAND. I am aware that this has happened, and it is kind of standards of practice after the fact, which is disconcerting to anyone rendering service and expecting reimbursement.

Certainly, we do not object to having reasonable standards, and we certainly concur that the scope of service under the program should be defined, but we do think that it is appropriate that this be established in advance. And I think the concern that your constituents referred to is a situation wherein, say, they rendered service to the best of their knowledge within the "ground rules" of the program and then have the intermediary come along after and say, "Well, we have a new set of ground rules, and that service rendered 3 months ago is not applicable."

Mr. CORMAN. Isn't it really up to the doctor who is responsible for the patient to make that decision? Do we need some rules beyond that to make the program work?

Mr. NOLAND. Certainly, the prescribing of additional services is within the scope of the practice of medicine. Therefore, it would seem appropriate to us that this be reserved to the physician. But I think—and it is probably the reason that the concept of utilization review is advanced—that in the presence of a third-party payer, there also should be an additional third-party reviewer to make sure that, let's say, the judgment of the physician involved is consistent with high-quality care and reasonable community standards.

Mr. CORMAN. I am just wondering what position you put the therapist in if he has a quarrel with the doctor.

Mr. NOLAND. It is not comfortable.

Mr. CORMAN. It seems to me he is at his peril. He must guess whether or not a certain category of patient is covered under medicare. But the doctor tells him that he wants this service carried out and that in the doctor's opinion the patient will improve.

It seems to me it would put the physical therapist in a pretty untenable position.

Mr. NOLAND. It can be. I think the physical therapist, however, should not hide behind this situation and say, "Well, I was only doing what the doctor said," if he really knows better.

But the other side of the coin that you illustrate also exists, that definitely worthwhile care has been provided and then judgments more determined, to me, on an accounting basis than a medical basis have resulted after the fact and put the physical therapist in a difficult spot.

Mr. CORMAN. Thank you.

The CHAIRMAN. Again we thank you, Mr. Noland, for coming to the committee.

Mr. NOLAND. Thank you.

The CHAIRMAN. Dr. Little.

Dr. Little, if you will identify yourself for our record, we will be glad to recognize you, sir.

**STATEMENT OF DR. KENNETH B. LITTLE, EXECUTIVE OFFICER,
AMERICAN PSYCHOLOGICAL ASSOCIATION; ACCOMPANIED BY
DR. JOHN J. McMILLAN, ADMINISTRATIVE OFFICER FOR PRO-
FESSIONAL AFFAIRS; AND KENNETH GOODALL, DIRECTOR OF
PUBLIC HEALTH**

Dr. LITTLE. Thank you, Mr. Chairman.

My name is Dr. Kenneth B. Little. I am the executive officer of the American Psychological Association, and I appear today on behalf of the association, whose 29,000 members includes 85 to 90 percent of the eligible psychologists in the Nation. I am accompanied by Dr. John J. McMillan, on my left, our administrative officer for professional affairs, and Mr. Kenneth Goodall, on my right, our director of public affairs.

THE CHAIRMAN. We are glad to have you gentlemen with us, and you are recognized.

Dr. LITTLE. My predecessor, Dr. Arthur H. Brayfield, appeared before your committee in March 1967. Because the burden of my message to you today is essentially the same as his then, I will be brief. But I want to emphasize that the problem to which we speak has grown in severity and visibility in the 2½ years since Dr. Brayfield testified.

That problem is the growing inadequacy of our present system for the delivery of health care, particularly since the advent of medicare.

The establishment by the 89th Congress of the right of elderly people in America to adequate health care was a most significant advance. We now realize, however, that this accomplishment has aggravated some old problems and created some new ones.

As Secretary of Health, Education, and Welfare Robert H. Finch and Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, recently stated:

"This nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by Government and the private sector."

They added that the "expansion of private and public financing for health services has created a demand for services far in excess of the capacity of our health system to respond."

I hope today to suggest a partial solution to this problem.

WHAT IS PSYCHOLOGY?

But first let me say a few words about psychology. Psychology is the study of human and animal behavior and related mental, emotional, and physiological states. It is, first of all, a scholarly discipline, taught and studied in colleges and universities. It is also a science, attempting to accumulate, verify, quantify, and interpret data on human and animal behavior. Finally—and most recently—it is one of the health professions. As such, it attempts to resolve or alleviate human and social problems.

The professional psychologist offers many services to the public, of which psychological testing is probably the best known. Some professional psychologists specialize in the treatment of mental, emotional, and behavioral disorders of the individual. In doing so, they perform virtually the same services as the psychiatrist who is engaged in psychotherapy.

There are many psychotherapeutic methods and techniques, some developed by psychiatrists, some by psychologists, and each used by both professions. In lieu of extending my discussion on this point, I should like now to request that this pamphlet, "The Role of Psychology in the Delivery of Health Services," a study commissioned by the Board of Directors of the American Psychological Association, be received at this time and be made a part of the hearing record.

The CHAIRMAN. Without objection, it will be included.

(The pamphlet referred to follows:)

THE ROLE OF PSYCHOLOGY IN THE DELIVERY OF
HEALTH SERVICES

WILLIAM SCHOFIELD

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THE ROLE OF PSYCHOLOGY IN THE DELIVERY OF HEALTH SERVICES¹

WILLIAM SCHOFIELD²

Departments of Psychiatry and Psychology, University of Minnesota

THIS article has a broader focus than implied in the formal title. The topic for contemplation and study is "Psychology and Health." This embraces the specifics of how psychologists contribute to the delivery of health services and includes those theoretical and research efforts having implications for the promotion and maintenance of health, the prevention and treatment of illness.

Consonant with a broad focus, health is understood in the Websterian sense of a condition of wholeness and well-being, freedom from defect or pain of the individual—soundness in mind *and* body. Mental health and illness constitute only a part, albeit large and important, of the total health domain. Similarly, psychology is understood to be a discipline in which both scientific and professional endeavors have a mutual, basic goal—the understanding of behavior, that understanding tested against the criterion of man's ability to predict and guide behavior.

The broadening of focus is in the interest of achieving a perspective that will facilitate evaluation of present roles and future possibilities, current problems and anticipated dangers. A broad focus can mean a blurred image if there is failure of definition.

Uncertainties as to direction can result when fundamental concepts are so imprecise as to convey no clues to feasible operations and no keys to appropriate evaluation. Such imprecision is true of the construct "mental health." The expansion and extension of this term and its popularity as a target of social interest is less a function of its inherent logical qualities than of its philosophical, professional, and political appeal. The problems

arising from its mercurial escape from definition permit two remarkably different semantic "solutions": (1) destruction; that is, there is no such phenomenon as mental health (inferred from the argument that there is no such thing as mental *illness*); and (2) superordination; that is, mental health is the ultimate all-encompassing state of functional integrity and efficiency to which other states are subservient. Neither of these is acceptable as a basis on which to appraise psychology's place among the health sciences and health professions.

In recent Federal legislation aimed at increasing the overall well-being of citizens, the statement of goals is such as to blur what previously may have been administratively distinct concerns for "health" on the one hand and "welfare" on the other. The softening of the borders between these two areas of concern seems to be fostered in part by placing them under the overarching concept of "mental health."³ To the extent that mental health is a field of psychological interest, such a perception of the place of mental health as the keystone in the affairs of mankind is welcome to some psychologists and worrisome to others—depending upon the individual mixture of scientific modesty and social motive.

In this essay, health is the paramount concept, and subsumes mental health, not vice versa. In this approach, there is no implication of lesser importance for mental as contrasted with physical well-being. The hierarchical consideration is introduced simply to correct for an understandable tendency of psychologists toward an implicit dualism (see Section 5, on the problem of inconsistent official policy) and, given that dualism, to attach greater importance to mental as contrasted with physical health.

¹ This article has been prepared for the Board of Directors of the APA, consequent to an invitation of the Board of Professional Affairs. The assistance of the Professional Affairs staff in Central Office is gratefully acknowledged.

² Requests for reprints should be sent to William Schofield, Box 393, Health Sciences Center, University of Minnesota, Minneapolis, Minnesota 55455.

³ An official of the National Institute of Mental Health, reflecting on the new range of problems coming under its aegis, commented that it might be better titled the "National Institute for Social Problems."

A further guiding mark is the recognition that, historically, modern psychology has been a science out of which has grown a profession (or group of professions). Our professional status is so recent, stemming essentially from developments of the past two decades, that we necessarily experience some insecurities and uncertainties. We may not have an adequate scientific base for even our present professional commitments, let alone a developed technology sufficient to justify the extent and variety of new demands that society appears eager to make of us. We are stressed between the need to be scientifically proper and the press to be socially responsive. As new opportunities challenge us to apply psychological knowledge, our academic discipline counsels us to caution. We are likely to be "damned if we do, and damned if we don't."

Life is short and the Art long;
the occasion instant, decision difficult,
experiment perilous.

Hippocrates

Finally, there is a firm conviction that all psychologists, scientists and practitioners alike, hold their respective views as to psychology's proper and primary role out of a sincere and *mutual* concern that their discipline will be pursued so as to assure the greatest good to the greatest number in the long run.

1. PSYCHOLOGY AND THE HEALTH SCIENCES

Is psychology a health science? Not as ordinarily perceived at first glance. It has to do with the scientific study of behavior and with "wonders of the mind." A great portion of its research is prestigiously (intrahouse) esoteric, utilizes infra-human subjects, and addresses questions seemingly with only remote likelihood of discovery that would lead to betterment of the human condition, broadly defined. There is nothing wrong in that; there is no reason why psychology should be generally perceived as a health science any more than geology. In its valued historic tradition and its continuing forward press, psychology as a branch of science has concerned itself with the discovery of laws governing the behavior of organisms. In human research, its focus on intelligence, learning, perception, cognition, skills, affect, attitudes, and interpersonal transactions of largely normal subjects has

generated information with potential relevance for understanding defects or disorders in these areas of human function. However, the experimental psychologist is rarely concerned to conclude a summary of his findings with a statement of their relevance for the treatment of some aspect of psychopathology (such as mental retardation, dyslexia, psychic impotence, school phobia, alcoholism, marital discord, etc.), and a conscientious editor of a scientific, nonprofessional journal would probably dissuade any such impulse toward application.

Is psychology a health science? At second glance, yes—because a large amount of the time and effort of psychologists, both in study, treatment, and prevention, is devoted now to a major form of illness (nonhealth), that is, so-called mental illness. It would be fair to say that psychology (unlike physiology) is not a health science, except that one prominent field of applied psychology addresses itself to the problems of *mental* health. This would permit a relatively circumscribed specification of psychology's role among health sciences and the remainder of this essay could concern itself with the ways in which psychologists, largely clinicians and counselors, contribute to investigation of and prescription and prophylaxis for mental illness or maladjustment.

A citizen-psychologist with equal concern for his responsibility to his society and to his profession, and inspired by a conception of the truly general, permeating, and multifaceted impact of psychological principles and problems on the total functioning of his society, will prefer a broad rather than a narrow perspective on most issues. Wide perspectives are encouraged by a proper hierarchy of the questions we put to ourselves.

Is psychology a life science? This question probably would achieve a higher level of affirmation than almost any other that might be put to members of APA. As a life science, does it not concern itself with the discovery of facts at every level and in every detail of human function in which primary observation is of macro- rather than microdimensions of behavior? Put another way, regardless of the nature of input (e.g., drugs, electrical stimulation of the brain), when the observed, recorded, and analyzed outputs are macrobehaviors of the intact organism (including verbal report, lever pulling, etc.), psychology is involved. Regardless of the form of stimulus, psychology is involved

if the responses under study are "outside the skin."⁴

Viewed in this fashion, as a life science, what are the boundaries that constrain psychology's inquiry?: nothing less than the boundaries of life itself—from conception to death. While the psychologically observable life of the individual, as defined above, does not begin with conception, certainly there is psychology in the motives, decisions, and successes (or failures) of the copulating partners. And even before birth there can be study of the activity level and extrawomb stimulus responsiveness of the nearly born. Between conception and death there is a complex ontogeny of maturational and involutional processes that involve psychological variables at every stage. In the study of the normal growth and decline of the "psychological person" there is a possibility of discovery at every stage, with potential relevance for the prevention of disorder, the promotion of health.

In brief, if we accept psychology as a life science we need only to acknowledge the possibility that its discoveries may have health-fostering applications at every level and in every dimension of its total endeavor.

The above is not intended solely as a semantic ploy to support *some* psychologists who wish to feel a stronger identity with the health enterprise than they presently enjoy through their participation in the mental health-mental illness arena. Nor is it motivated primarily to provide argument and support for APA to seek enlarged roles and increased subsidy from the Federal agencies engaged in the design of programs with a new emphasis on research and service to achieve and maintain higher levels of individual health—physically, socially, and psychologically. It is pertinent to both the identity problem of the "clinician" and the policy orientation of APA. But its greater relevance is in encouragement of the citizen-psychologist, regardless of his specialty—whether he be undergraduate teacher, psychophysicologist, learning theorist, or psychotherapist—to see his profession in the broadest possible perspective and to

have an enhanced concern that his profession is contributing its fair share to the welfare of the society that supports it.

There are identity problems, insecurities, and rivalries within our house that at least obfuscate when they do not obstruct our professed goal that psychology will be a socially responsible profession. This was exquisitely exemplified in recent testimony before the Senate Committee on Government Research when a distinguished experimental psychologist felt constrained to make the following identification: "While I am not a member of the health sciences, I am a member of the life sciences." He went on to extrapolate from his own basic animal research to the possibility that we might achieve a future capacity through appropriate prescription of "drugs and psychological procedures," to improve the learning capacity of individuals (treat mental retardation?), or to enhance specific abilities (correct deficiencies?) (Amrine, 1968). Is this not health science?

Psychology in its research establishment can well use more support than it is presently getting. At the same time, it can expand the potential social relevance of even its more basic inquiries. A profession-wide interest in the health of the nation, defined in the expanded terms of recent Federal legislation, can make possible larger and more fruitful channels for the interchange of resources and talent by which our profession and society are mutually supporting.

How does psychology presently distribute its scientific energies and interests vis-à-vis health problems? A crude but nonetheless instructive answer is afforded by noting the comparative frequency with which certain areas are represented by indexed articles in the *Psychological Abstracts*.⁵ This was done for the years 1966 and 1967, with the results reported in Table 1. A reasonably extensive but not comprehensive list of topics was chosen to cover the entire life span and to include both more broadly and more narrowly defined health areas. No attempt was made to distinguish between research and other contributions, except in the area of psychotherapy, where the *Abstracts* provides separate indexes. A total of slightly over 2,000

⁴ Psychophysiology can be applied properly or loosely. An investigation of the effects of visual flicker frequency on concomitant brain waves is not psychology simply because a PhD in psychology is conducting it. An analysis of verbal reports of anxiety evoked at various levels of flicker is psychophysiology—even if conducted by a PhD in physiology.

⁵ The roughness of this index is reflected in part by the fact that not all abstracted articles are authored by psychologists or even drawn from psychological journals. Nevertheless, the great bulk of items in the *Abstracts* do meet these criteria.

TABLE 1
COMPARATIVE FREQUENCY OF INDEXED ARTICLES BY
CERTAIN HEALTH-RELATED AREAS AS INDEXED
IN *Psychological Abstracts*, 1966-1967

Area	Percentage of all articles	
	1966 ^a	1967 ^b
Birth, abortion, etc.	2	1
Fertility	— ^c	— ^c
Population control	— ^c	— ^c
Mental retardation	14	16
Educational disabilities	4	4
Accidents	1	— ^c
Highway safety	— ^c	— ^c
Psychosomatics	3	3
Alcoholism	5	5
Hospitalization, other than mental	3	1
Smoking	1	— ^c
Cancer	2	— ^c
Heart	2	5
Surgery	— ^c	— ^c
Pain	2	2
Psychoneurosis	8	7
Schizophrenia	18	27
Psychotherapy, general	22	16
Psychotherapy, research	2	2
Aging	2	2
Suicide	2	2
Death	2	2

^a *N* = 2,071.

^b *N* = 2,648.

^c Less than 1%.

index entries was tabulated for 1966 and over 2,500 for 1967.

With the total health domain only partially represented by the selected topic areas, it is clear that insofar as publication is concerned the activities of psychologists have three major foci: psychotherapy, schizophrenia, and mental retardation. Certainly schizophrenia and mental retardation, in light of the number of persons afflicted, deserve a large effort.⁶ But as major health problems, in regard both to incidence and associated mortality, cancer, heart disease, and stroke have been the target of a well-funded research, treatment, and prevention enterprise following the 1964 report of the President's Commission on these illnesses. These present an opportunity for psychological research that so far has been largely neglected. Likewise, the area of accident research and especially highway safety

are strikingly neglected. It is unnecessary to comment on the implications from these data that psychotherapy is an overpromoted and underresearched focus of psychological interest.

What factors determine this pattern of scientific interest? Is it primarily the relative availability of research funds? Is it because mental illness is generally perceived as inherently more "psychological" than proneness to accidents? Is it because there is an apperceptive mass relative to schizophrenia and a stable and large subject pool, both contributing to a certain magnetic or inertial effect in attracting the interests of clinicians? Is it because the predominant curricular emphases in graduate programs in professional psychology do not provide the kind of methodological expertise required to mount effective research into the etiology and prevention of highway accidents, or into the psychological factors in the acceptance of birth control methods, or into the effects of preoperative preparation on the response to surgery? Is it because our academic departments do not provide our students with examples of innovative research by breaking ground outside of the mental health sphere? Is it because APA has not sufficiently surveyed, catalogued, and communicated the extent of available governmental and private support for research into health areas that are presently less visible (less lobbied?) than mental illness and mental retardation?

Very likely all of these play some determining role in what has been psychology's restricted contribution to study and improvement of the nation's health. There is now new stimulus to a broader role for psychology as one of the health sciences in the enlarged programs for research and service impinging upon all facets of human effectiveness. This is illustrated by the concern in the National Institute for Mental Health (NIMH), the National Institute for Child Health and Human Development (NICHD), and the Social and Rehabilitation Services (SRS) with research into and correction of the effects of psychosocial deprivation. In the expanded vistas both for research and for clinical services, psychology has a potential laboratory in which the interplay and feedback between investigation and application can serve not only the growth of our science and our profession but in turn can enhance the validity of its contribution to our supporting society.

⁶ Officials responsible for directing Federal programs in the field of mental retardation view psychology departments as traditionally "disinterested" in this area.

2. PSYCHOLOGY AS A HEALTH PROFESSION

Is psychology a health profession? Do psychologists render services of a prophylactic or therapeutic relevance for the maintenance and improvement of human functioning? Are there *clinical* applications of the principles and methods of psychology?

The Psychology Section of the 1966 National Register of Scientific and Technical Personnel elicited replies from 19,027 individuals who indicated their "greatest scientific competence" to be in psychology (Boneau, 1968b).⁷ Of this number, 36% indicated their specialty field to be clinical psychology, a figure three times larger than that for any other specialty. If the specialties of counseling and guidance (11%) and school psychology (6%), also clinically and service oriented, are added to this number, over half of the American psychologists profess their greatest competence in specialties having direct relevance for health, adjustment, and performance. That portion of psychology's manpower potentially relevant to the provision of services having impact on personal health is relatively quite large, but these figures alone would give a distorted picture. Of the total sample, how many see their activities as related to the field of mental health? And of the clinical and counseling psychologists, how many are employed in direct service activities?

Of the sample of 19,027, nearly two-thirds (61.2%) saw their product or service as related to the field of mental health. This is more than the combined numbers of those identified with the clinical, counseling, and school psychology fields (53%), and included those who viewed their teaching, research, or other activities as pertinent to mental health. Of the clinical and counseling specialists, only 41% and 33%, respectively, reported engagement in direct service as their *primary* (not necessarily full-time) activity. Of the total sample of psychologists, only one-fourth are primarily engaged in direct service activities as clinicians or counselors.

How are these figures to be appraised? They indicate that a majority of American psychologists see their primary activities as germane to at least one sector of health, that is, mental health. They reveal that an appreciable but very much smaller

number are engaged in rendering direct clinical services to people with problems. They do not show the extent of clinical (or research) activities of psychologists in health problems other than "mental." (But as indicated by other data, see Table 1, there is evidence that psychology's present interest in health is narrow rather than broad.) They do suffice to support an affirmative answer to our question: Psychology very definitely is one of the health professions.

Further appraisal is in order. In light of psychology's major purposes (see Section 5), is the above indicated participation in the health enterprise satisfactory? Does it approach the optimal? Individual psychologists will respond to these questions differently as a function of their values and their perceptions of the total present content and impact of their science and profession.

The more socially oriented psychologist may feel that we are making an insufficient contribution to the psychological service needs of the population if less than one-half of the clinicians and counselors report direct service as a primary activity. He may see this fact, together with manpower shortage data, as an argument for training of more clinicians who will invest more time in service activity.

The science-oriented psychologist may be pleased to think that in light of the present state of our developed knowledge and clinical techniques it is good that more than half of the psychologists with "clinical" competence are not primarily engaged in service. He would prefer to imagine they are researching. Actually, only 6% of the sample of clinical and counseling psychologists indicate research as a primary activity (Boneau, 1968b). Fifty percent of psychologists with "clinical" skills are engaged in teaching, "management," or other nonservice and nonresearch activities. That less than 1 out of 10 clinically oriented psychologists has a primary investment in research has serious implications for the improvement of our practices and for increments to the scientific foundation of our profession. It raises questions also about our training models.

The scientific competences of the National Register respondents were in 12 specialty fields. In addition to the three "clinical" areas already mentioned, these included developmental, personality, educational, experimental, psychometrics, social, industrial-personnel, engineering, and general. It is

⁷ The APA membership office listed 27,250 members in 1968.

notable that every one of these fields had some representation by psychologists who viewed their service or product as related to the field of mental health! The percentages of such representation ranged from a low of 4% (engineering) to a high of 84% (school). Particularly notable is the fact that 50% of the "experimentalists" so viewed their activity! Is this an artifact of questionnaire ambiguity, of a too broad concept of mental illness, or of distorted motives of the questionnaire respondents? (They were not applying for grants!) Or does it suggest that even the hard-headed, brass instrument, blood-and-bone cgs-oriented psychologist when contemplating the nature of his enterprise in the seclusion of his office is able to perceive its place in the total push of psychology and to see, in turn, that all of psychology is potentially relevant to how the human organism adapts or fails? Perhaps intramural jealousies, suspicions, and quarrels among apparently divergent groups of psychologists hide a truly shared basic commitment, and perhaps we may be sanguine that our professional home will continue to stand united.

That psychology is broadly perceived as a health profession is further attested by the extent to which concern for protection of public welfare has led to legislation providing statutory definitions of and limitations on the practice of psychologists offering direct services. Such legislation has generally aimed to place the same restraints and afford the same privileges (e.g., confidential communication) as characterizes the legal recognition of other branches of the "healing arts." As of 1968, 37 of the 50 states had licensing or certification laws governing the practice of psychology (APA, 1968a).

An even clearer manifestation of psychology's role in delivery of health service is the growing recognition of the diagnostic and treatment services of psychologists as reimbursable under the provision of major health insurance policies. This has been a slow development until recently. Most major underwriters have been understandably slow to provide coverage for psychiatric treatment in light of the ambiguities surrounding mental illness and prognosis (Somers & Somers, 1961). Increasingly, in response to pressures from insured groups and especially to effective representations by APA committees, many comprehensive medical insurance policies provide reimbursement for some

amount of psychiatric care. Some companies writing such policies have been willing to cover diagnostic or other services of psychologists if prescribed by the responsible physician. In the last few years a growing number of the largest underwriters of hospital and medical insurance have provided reimbursement of psychologists' fees for psychotherapy without requiring a physician's referral (APA, 1968a).

In both the drafting and successful passage of state laws governing the definition of psychologists and the offering of psychological services, and in the productive dialogue between psychologists and health insurance underwriters, APA has provided interest, active support, and appropriate resources.

Further evidence of APA's perception of and concern for psychology's role in the delivery of health services is found in the testimony of our past Executive Officer at Congressional hearings on Medicare legislation: "We submit that the public interest is not served by . . . restriction on direct access of patients to services offered by a psychologist [Brayfield, 1967]." He was testifying in support of an amendment that would provide Medicare recipients with coverage for psychological services without a physician referral.

Finally, note should be made that the Federal legislation of 1965 governing the staffing of community mental health centers not only provides a role for psychologists in the delivery of services but allows the possibility of their holding overall responsibility for leadership and programming of such centers. Responsiveness of psychologists to that possibility is ably represented in an official APA position paper, "The Community and the Community Mental Health Center" (Smith & Hobbs, 1966).⁸

The contribution of psychology to the overall health apparatus of our nation is not limited to the avenue of direct service. There are indirect contributions, with implications for delivery of service, in the research and teaching activities of psychologists. It has previously been noted that health-

⁸ The report of the National Advisory Commission on Health Manpower (1967) deals only with physicians, dentists, and nurses. Psychologists are not mentioned. Likewise, the reports of the various task forces of the National Commission on Community Health Services (1967a, 1967b, 1967c) make almost no reference to psychological services. In some ways, our status as a health profession is less visible than we might wish it to be.

related research by psychologists appears less generally distributed over the total health-illness domain than would seem desirable, quite apart from the question of the quality and import of those investigations that are massed in the mental health area. The impact on service of the teaching activities of psychologists is even more difficult to appraise. To the extent that they do participate in the training of physicians, nurses, social workers, not to mention other allied health professions, their potential influence is very great. This influence has at least two channels: indirect effect upon the quality of service through sensitizing other professionals to the psychological variables in health and illness and the appropriate psychological approaches to influencing health-related behavior, and direct effect in the encouragement of other health professionals to turn to psychologists when indicated for help with clinical health problems. It would be informative for APA to conduct a survey to determine the extent and variety of our members' participation in *formal* instruction of medical students, residents, physicians, nurses, social workers, and other health professionals.

In all these ways—by self-identification, by service and research, by legislation, by insured coverage of professional fees, by federally legislated provision for leadership in comprehensive health centers, and in teaching of other health professionals—psychologists clearly are invested in the health enterprise and play a significant role in the delivery of health-related services. They are doing this in sufficient numbers and with sufficient competence to have achieved recognition and acceptance among the allied health professions. “Despite formal protestations, medicine appears to have given psychology *de facto* acceptance as a limited health profession *rather than merely an ancillary one* [Wardell, 1963, italics added].” In today's medical complex of specialization are there any unlimited health professions?

Psychology is a health profession. It is delivering services in the health area, especially that of mental health. Can its service role be expanded? Should it be? Should larger numbers of psychologists be trained in the clinical area than is true at present? Should the range of health-related services be expanded? Should psychology's research talent, presently concentrated on problems of mental illness, be encouraged toward a broader

study of the interaction of psyche and soma in all manifestations of human dysfunction? An affirmative answer to any of these queries brings immediate confrontation with very basic problems for professional psychology.

3. EXPANDING OPPORTUNITIES

We are in a period of intensified concern for the physical and emotional health of our population. In the last two decades there have been major research attacks on our most crippling diseases and programs developed to improve provisions for the care of victims of those diseases. The discovery and national dissemination of poliomyelitis vaccine and the Federal and state funding of comprehensive community mental health centers are but two examples. While earlier emphasis on research to discover therapeutic and preventive agents continues, current concern is with the establishment of mechanisms to assure that no segment of the population will be without access to adequate health services. This effort involves two components: creation of a sufficient pool of skilled health personnel and assuring that their services are made efficiently available to the public.

The demand for health services in our nation is greater than at any previous time. This is due in part to broadly based Federal welfare programs and in part to the increasing portion of our population who can afford, partly through prepaid health insurance, to demand top quality health services. “At the end of 1967, almost 163 million Americans were protected by one or more forms of private health insurance. This total represented 83% of the civilian population [Health Insurance Institute, 1968].”

Insurance for the treatment costs of mental illness is a relatively new development (Scheidtmandel, Kanno, & Glasscote, 1968). There was little demand and little supply prior to 1950. The growth of comprehensive medical insurance, coupled with an increased availability of psychiatric help, made it appropriate to question why there should not be mental health insurance.⁹ A pioneering research demonstrated the feasibility of such cover-

⁹ By 1959, 64% of the 12,000 psychiatrists were in private practice (American Psychiatric Association & National Association for Mental Health, 1959). As early as 1953, psychiatrists began to criticize the exclusion of mental illness from coverage under health insurance policies (Bennett, Hargrove, & Engle, 1953).

age. In 1959, Group Health Insurance, Inc., of New York City, with the American Psychiatric Association and the National Association of Mental Health as cosponsors, and with Federal fund support through the National Institute of Mental Health, offered short-term psychiatric benefits, including office treatment, to a sample of 76,000 persons—30,000 subscribers and their 46,000 dependents. Utilization of psychiatric services by this sample was studied during a two-and-one-half-year period. It was concluded that provision of such coverage was both economically feasible and of definite value to the subscribers (Avnet, 1962). Other studies have yielded corroborating evidence on the practicability of such insurance (National Institute of Mental Health, 1965).

As noted in Section 2, there is increasing recognition by insurance carriers of the competence of clinical psychologists to render those kinds of service, notably psychotherapy, previously restricted by insurance clauses to physicians. It is likely that state laws governing the insurance industry may be amended to require that when treatment of mental illness is covered by policies, the appropriate services of clinical psychologists will be reimbursable (Goodman & Shapiro, 1968). "Both the continuing development of the mental health treatment team and the present shortage of mental health personnel argue strongly for covering the services of all mental health disciplines, including the clinical psychologists, the psychiatric social workers, and the psychiatric nurses [National Institute of Mental Health, 1965]." ¹⁰

Expansion of voluntary insurance plans to provide coverage for an increasing number of the population, the inclusion of benefits for mental illness, and the recognition of the psychologist as competent to render appropriate and reimbursable service under such plans provides one very important and growing avenue by which psychology can participate in the delivery of health service. It is but one of several avenues, however, and clearly not the most significant.

Within Federal welfare legislation there is increasing opportunity for psychologists to contribute to the nation's health program under the newly broadened concept of health as entailing the total

functioning integrity of the individual—physically, socially, and psychologically.

In particular, staffs of the NICHD, of the Community Mental Health Centers Staffing Branch of NIMH, of the Bureau for Education of the Handicapped of the Office of Education, and of the Vocational Rehabilitation Administration and the Administration of Aging under the new Social and Rehabilitation Services of the Department of Health, Education and Welfare express a number of concerns that have vital implications for psychology's role in contributing to the improvement of our nation's health: (a) they are welcoming of any expression of interest on the part of psychologists in the problems with which they grapple; (b) they feel a particular need to gain the interest and help of psychological specialists other than the clinician; (c) they offer special opportunity for contributions from the developmental and the social psychologist; (d) they find the typical PhD-clinician inadequately prepared to cope effectively with psychological problems that are outside of the usual psychiatric domain; (e) they see a need to break the established professional molds in developing adequate numbers of appropriately trained personnel to provide front-line services; (f) they have funds to support research and training, pilot programs, and program evaluation; (g) they are vitally engrossed in asking new questions, finding new ways; (h) they want more from psychology than they are presently receiving and are ready to look to resources other than the established academic departments. ¹¹

The staffs of these agencies, including psychologists, while generally expectant that psychology has much to offer toward the solution of their respective charges, rarely perceive the typical "Boulderized" PhD-clinician as likely to play a very central role either in research or direct service. To some extent this is because they are aware of the marked shortage of such clinicians. To some extent this is because they are not aware of the degree to which some clinical psychologists have extended their horizons; and to some extent this is because they see clinical psychology to be too psychiatry-and-individual-therapy oriented. Some examples will be helpful:

¹⁰ The first comprehensive major medical group insurance "as we know it today" was not offered until as recently as 1954 (Health Insurance Institute, 1968).

¹¹ These observations were made during a series of visits in July 1968 to responsible officers and staffs of the Federal agencies named.

1. The NICHD has sponsored an interlocking series of conferences and colloquia on anthropology, experimental psychology, developmental psychology, behavioral science in pediatric research, and longitudinal studies. Some selected quotes:

The most pressing need in developmental psychology is for more people. . . . There are so few developmental psychologists that it would weaken the field to bring any to Washington [National Institute of Child Health and Human Development, 1964].

The OPD [Pediatric outpatient department] provides a unique laboratory for research . . . because of the easy access to study subjects it provides. Behavioral scientists often do not see children until they enter nursery school or other special schools at the age of three or four years, and many problems need to be studied much earlier than this [NICHD, 1965].

The behavioral scientist can help to identify unintended consequences of treatment which can lead to social or personal pathology. For example, he can bring useful perspective to analysis of factors that affect the consumer's ability to make use of advice he receives from his physician [NICHD, 1967].

The research and training funds of NICHD are presently distributed over the following major subject areas: learning process—41%; developmental psychology—17%; personality development—14%; early cognitive development—14%; the communicative process—14%.

2. A social psychologist, on the staff of a community center, is training indigenous neighborhood leaders to provide focus and voice for self-generating community action plans.

3. The Social and Rehabilitation Services, through its Office of Research and Demonstrations, has contracted for a study of the social, economic, and psychological factors contributing to the use of Medicaid benefits by medically indigent persons. Included will be a study of health-related knowledge, attitudes, and practices in relation to the use of Medicaid.

4. The 1965 amendments to the Vocational Rehabilitation Act and related legislation have considerably broadened the scope of the programs and services funded under the Vocational Rehabilitation Administration (VRA). Eligibility for rehabilitation by virtue of "mental disability" defines the latter to include: "behavior disorders characterized by deviant social behavior . . . which may result from vocational, educational, cultural, social, environmental, or other factors [U. S. Department of

Health, Education and Welfare, 1966]." VRA is only one among several divisions of the Department of Health, Education and Welfare in which study, prevention, and treatment responsibilities include persons diagnosed as suffering from "psychosocial deprivation."

5. The Office of Education, in its concern with the general well-being of the school-age child, perceives a need for the school psychologist to expand his study of the individual child to include an appraisal of the total social matrix of the child. There is high priority for studies of the learning process in the natural setting of the classroom.

While many of the staff responsible for programs such as these seem clearly friendly toward psychology and eager for help from psychologists, they are not without some justifiable skepticism. Certain reservations about psychology's contribution to health research and service are reflected in comments such as the following:

Each training program [psychology department] seems to have a special focus or bias—for example, on operant conditioning techniques. They produce specialists rather than generalists.

Psychological research has been too focused in institutional settings. There is need for more "outreach" research in which the community is the laboratory.

The psychologist [clinical] seems unprepared to integrate himself in an atypical [nonpsychiatric] multidisciplinary approach.

The psychologist seems unsophisticated with regard to *normal* behavior.

The psychometric orientation of the psychologist inhibits his creative thinking.

Health professionals, including psychologists, have been too much concerned with licensure and professionalization and too little concerned with service.

Psychology seems like the old maid who loudly proclaims her virginity long after it ceases to be of any interest to anyone.

All of the Federal programs present opportunities for psychologists to participate, and to participate in all three spheres of research, training, and service. They are alike in representing a programmatic response to what is a greatly expanded concept of mental health. The individual's mental health is considered impaired if any condition is present that interferes with his achievement of his potential, and such impairing conditions are inclusive of psychosis at one extreme and inap-

appropriate vocational placement at the other. The range for potential contributions of psychology is accordingly broad—an immediate potential for research contributions, and an ultimate potential for delivery of valuable services.

Even the broad definition of mental health, however, does not encompass the total possibility for psychology to play a vital role in the delivery of health service. There remains a large and as yet only superficially mined area of the psychology of physical illness. To date there has not been a widespread call to psychologists to assist in the study and treatment of diseases other than mental, with the possible and important exception of the programs for vocational rehabilitation of the physically handicapped. Certainly there has been no parallel to the development of "clinical psychology" as it evolved out of the relatively circumscribed psychiatric burdens of the post-World War II period. Such an institutionalized demand and training program is unlikely to come.

This leaves it up to the initiative and imagination of the individual psychologist to perceive problems for psychological investigation in the manner in which people are susceptible and responsive to the major physical illnesses. Thus far only a smattering of psychologists have interested themselves in clearly medical nonpsychiatric problems. Rarely is a physically ill person not in some degree psychologically ill, and his response to treatment not in some degree influenced by the expectations that his physician has succeeded or failed in arousing. With every illness there is reason to be concerned with psychological factors in etiology, cooperation in treatment, response to therapy, atypical course, delayed convalescence, etc. The psychological response to physical aspects of the hospital environment is deserving of study. In each of these areas for psychological study there is a possibility for discovery that may have import for eventual delivery of an improved health service.

The potential for psychology to contribute to health services outside of the mental health area is not likely to be realized unless the current pattern for the training of the scientist-clinician undergoes a very marked correction of its rather exclusive focusing on psychiatric illness, psychiatric patients, and psychiatric services. There will be a continuing need for psychologists trained with this emphasis. It would be well, however, for a few centers to explore modifications of their training

programs, especially in regard to minor studies and internship, so as to produce a desirable variant, the medical psychologist. He would be a scientist-clinician, like his more common prototype, but with a particular sophistication in physical illness, equipped to research and consult with regard to the psychological concomitants of physical disease.

Research in the psychological dimensions of mental and physical illness does not exhaust the possibilities for significant psychological contributions. There is the domain of health behavior—the behavior of the healthy individual with respect to the perceptions he has of his health and of possible measures he may take to protect and preserve it. What determines the use of the annual physical checkup, the periodic dental visit, the regular chest X-ray, the antifu inoculation? A model to account for health behavior has been proposed (Rosenstock, 1966). This model entails the individual's *perceptions* of his susceptibility to an illness, the seriousness of that illness, and the benefits to be derived from taking preventive action. It also includes the barriers to action and cues that trigger action. There are challenging problems for psychology in the definition and measurement of all of these variables and in analysis of their interrelationships in the determination of health behavior.

Because the entire field of health services research is dependent upon interdisciplinary efforts by the broadly defined social and behavioral sciences, together with industrial engineering, computer science, and epidemiology, it is fully to be expected that psychologists *must* play a greater role in such research if it is to contribute to better health through improvement of services [*italics added*].¹²

The opportunities for psychology to play a much expanded and valuable role among all the health-related disciplines are so many and so varied as to defy cataloguing. Will we be able to grasp these opportunities? This will depend in part on our resources (manpower) and on our talents. But some opportunities may be lost to us, by default, if we are bound too rigidly to current perceptions of our role as a mental health profession and too inflexibly committed to a single level of training for professional psychology.¹³

¹² P. J. Sanazzaro, personal communication, July 1968.

¹³ Federal agencies with expanding needs for new training programs are alert to the rapid expansion of community colleges and junior colleges. They may look to these to supply academic instruction if the prestigious university departments are not interested.

4. PERSISTING PROBLEMS AND NEW OPPORTUNITIES

To raise the level and broaden the scope of our nation's health establishment, as requested in President Johnson's health message to Congress, March 4, 1968, requires a common triad of programs for health and welfare agencies representing the life span (from NICHD to the Administration on Aging): research, training, and service. All three of these, but the last two in particular, bring immediate confrontation with the problem of manpower. To expand greatly the availability of critical health services to our population demands the efficient training of larger numbers of skilled personnel and the development of more efficient methods of rendering skilled service. Relative to actual and anticipated demands, there are current shortages of personnel in all of the presently recognized health professions. It is recognition of such shortages, recognition that significantly increased numbers of such professionals are not likely to be achieved, and recognition of inefficiencies and inadequacies in the present practices of such workers, especially physicians, that is generating a willingness to explore more appropriate training programs for the established professions, as well as the creation of new types of health workers. There is general recognition of the desirability of developing "career ladders" and the possibility for an orderly progression in amounts of training and levels of responsibility. This contrasts with psychology's present "all or none" view of who is qualified to practice psychology.

Both Veterans Administration and Department of Health, Education and Welfare legislation regarding health service delivery reflect the impact of the recommendation of the President's National Advisory Commission on Health Manpower (1967) that "the Federal government give high priority to the support under university direction of experimental programs which train and utilize new categories of health professionals."

The Veterans Administration is mounting a four-phase program to improve the delivery of its health services. One phase will involve the design and implementation of new training programs to produce technician-assistants for the traditional health professionals. The Veterans Administration hopes that the universities will be interested in contributing to these nondegree training programs.

Health manpower experts in the Department of Health, Education and Welfare see a need for redefinition of the roles of *all* health workers. The Health Manpower Act of 1968 (PL 90-490) provides funds to support a reexamination of traditional roles as well as to provide training programs for new kinds of health personnel.

Psychology, in both its present and potential contribution to the delivery of services, is faced with a very clear manpower problem. The present shortage of psychologists has been extensively documented, especially with respect to the mental health area (Albee, 1959). Awareness of demand-supply deficits is most commonly expressed with respect to the number of PhD-clinicians presently in the manpower pool, and the number presently in training in doctoral programs. Despite repeated recognition that the existing shortages will never be erased as long as the "demands" are uncritically defined in terms of PhD psychologists (Arnhoff, 1968), and despite repeated acknowledgment by the psychological establishment that some attention should be paid to the development of subdoctoral training programs (APA, 1959; APA Education and Training Board, 1955; Clark, 1957; Kelly, 1950), the responsible academic community has shown a consistent reluctance, or inability, with only a few exceptions, to develop more rational programs for professional, service-oriented training than the 1949 Boulder model. With nearly 20 years of experience with the PhD scientist-practitioner model, the most recent conference on training for clinical psychologists was unable to surrender the notion of the doctorate as a *sine qua non* for professional psychological practice (Hoch, Ross, & Winder, 1966). It specifically rejected MA-level training of clinical psychologists. Many of the strongest academic departments appear unwilling to turn any sizable portion of their resources and talents to the subdoctoral training of mental health specialists (Boneau, 1968a).

If psychology so far has been clearly conservative in the development of professional resources for the problem of mental illness as traditionally defined, it is not surprising that it shows reluctance to break the mold when addressing itself to a new and broader context—community mental health. The Boston Conference on the Education of Psychologists for Community Mental Health sounded the note of professional rectitude that is almost a hallmark of such assemblages:

It was evident that participants were thinking for the most part in terms of doctoral programs. . . . Interest was also expressed in the contributions of people with less than doctoral training to community psychology. . . . There was general agreement, however, that neither postdoctoral nor subdoctoral training will serve the needs of community psychology without a solid nucleus of professional education at the doctoral level. To ensure the development of the field, first priority must be given to doctoral programs at this time [Boston University & South Shore Mental Health Center, 1966].

A basis may exist for hope that, with a combination of enlarged social pressures and increased confidence in our professional status, American psychology may be ready to move toward training of the sort of cadre of technical assistants that would enlarge the impact and increase the efficiency with which psychological expertise is applied to human problems. A recent survey of the attitudes of members of the divisions of clinical, counseling, and school psychologists and of chairmen of graduate psychology departments elicited the following findings (Arnhoff & Jenkins, 1969):

1. There is a positive relationship between the amount of contact respondents had with subdoctoral psychologists and their evaluation of the quality of work done by such people. Three out of four respondents *with much contact* rated the subdoctorate's counseling performance as "good" or "excellent."

2. The tasks that would be specifically and totally proscribed, even under supervision, for performance by subdoctoral psychologists by the *largest* proportion of respondents were: assessment of organic problems—26%; diagnostic interpretation to client or patient—31%; child therapy—29%; adult therapy—31%; group therapy—28%; marriage counseling—25%; projective personality assessment—24%. At the most, *only a third* of the sample would totally prohibit the subdoctoral person from certain tasks, and these restrictions were largely in the area of "counseling."

3. Nearly 9 out of 10 of the survey sample favored the development of subdoctoral training programs in certain skill areas.

4. Approximately 70% of the respondents indicated willingness to have a subdoctoral program in their department, agency, or organization and to participate in the teaching or supervision of such trainees.

These figures are in striking contrast to the fact

that of the more than 200 graduate departments of psychology only 16 offer MA degrees in clinical psychology and only 15 confer the MA in counseling and guidance (U. S. Department of Health, Education and Welfare, 1965). These departments produced only 126 MAs in the clinical area and only 246 in counseling in the 1963–64 academic year. But this presently small annual production of formal subdoctoral degree programs is not without significance for the manpower and service programs. The National Register data show that as many as one-third of all responding psychologists hold only a master's degree; this figure has been constant over a seven-year period (1960–66).

Is not the time ripe for psychology to put together the data on service demands, program opportunities, and manpower and make a socially responsible decision to lend its considerable and vital expertise to the mounting of reasonable programs of training for psychological service workers?

It is likely that NIMH would be interested at this time in providing funds and other support in a mutual endeavor with APA to explore in detail the nature and extent of service opportunities for subdoctoral psychologists and the content and emphases of optimal training programs for such workers. APA's Joint (E&T, BPA) Subcommittee on Subdoctoral Education has urged that such an investigation be made. And our representatives to a joint conference with the National Association of Social Workers (NASW) on "The Use of Non-professionals in Mental Health" have concurred in a recommendation that APA and NASW establish an articulated Manpower Research Unit to examine the expanding needs for new types of mental health workers.¹⁴

Is it already too late for us to have the kind of impact on such programs that we might consider vital to their validity and to the competence level of their products? American psychology, through its academic centers and its national organization, has not provided leadership or programs optimally responsive to the social demand for psychological services.

¹⁴ The American Psychiatric Association, in collaboration with a state mental health agency, a private research institute, a university psychiatry department, a state hospital, and a community mental health center, has developed a proposal for a five-to-seven-year study of psychiatric manpower utilization and impact.

Psychology has never formally come forth with a model, a position, or data to provide clear, expert opinion on the country's needs for psychologists [Arnhoff, 1968, p. 313].

We have been pleased as long as these statements have concluded that there was a great need for more of us, more psychologists trained in our image, that is, PhD scientist-practitioners.

Society and its officers responsible for finding and training new kinds of mental health personnel have not been able to wait for the psychological establishment to be responsive. Faced with the general reluctance of the academic departments to concern themselves with the training of technicians or assistants, Federal, state, and private agencies have funded and staffed programs to train persons to render direct "clinical" help to retarded children, disturbed children, schizophrenics, discharged patients, and other special groups (Arnhoff, Jenkins, & Speisman, 1968). It is not clear how much psychology has to offer to such training programs. The impact of these various new kinds of mental health workers has not been measured yet. It may prove that psychology has missed an opportunity to make a significant teaching contribution. More significantly, psychology may be missing out on a variety of excellent natural laboratories for the study of very central phenomena related not only to mental illness and human adjustment but to more basic issues in social psychology and learning theory.

Those who would fault psychology for an apparent neglect of its responsibilities may not be entirely fair or reasonable. A sifting of the sum total of strictly scientific psychology for facts, principles, and techniques having clear application in the management of severe mental retardation, or the rehabilitation of the discharged patient, might result in a very small yield. With the total goals of the enterprise in view, it might be wasteful for any sizable component of psychology's limited manpower to be invested in training for or indirect rendering of what in large measure may be more properly the purview of social work.

Yet that possibly small yield of pertinent psychological principles and methodology could be of considerable import. What if the readjustment of the discharged patient is attempted without objective appraisal of his vocational potential and aptitudes? What if the "social interaction thera-

pist" who is to work with chronic schizophrenics has no basic knowledge of reinforcement theory or operant conditioning? What if the hospital aide is uninformed with respect to the theory of small groups? Do the things we know have relevant application in certain clinical contexts? Would workers with certain kinds of psychological training perform significantly better than workers without such training? This is an empirical question. We may lose the opportunity to study it if we remain more concerned for our purity than our potency, and reluctant to discover that persons with only "partial" training can perform certain functions as well (if not better!) than persons with full professional education.

One of the reservations that has been expressed as to the desirability of a complement of subdoctoral technical assistants is that they would be only briefly satisfied with their subordinate, supervised service role and that they would soon be frustrated by the lack of opportunity for "advancement." The correctness of this caveat would seem somewhat belied by the nearly 3,000 MA-level psychologists who have been active in psychology for more than 10 years (Compton, 1964). We could learn much from a survey of the job satisfactions (and frustrations) of this sample of subdoctoral psychologists.¹⁵ We have already some limited data suggesting that MA-level psychologists are more content with their role in a state hospital setting than are their PhD colleagues (Moss & Clark, 1961).

This expectation of vocational frustration possibly reflects a certain element of projection on the part of the PhD psychologist. Do we not recognize the existence of persons with a primary if not exclusive service interest? As psychologists, do we not have some methodology to enhance selection of persons whose pattern of motives, interests, and aptitudes make it likely that they would achieve stable and satisfying adjustments to technical service roles. One of the possible reasons for being less than satisfied with the overall level of contribution by our scientist-practitioner PhDs may be that we have not made optimal ap-

¹⁵ Insecurities and status preoccupations are suggested when the person with less than a doctoral preparation is referred to as "subprofessional." Experienced, competent, and dedicated psychologists are justifiably alienated by such categorization. The term "subdoctoral" is objectively descriptive. The term "subprofessional" is needlessly pejorative.

plication of our very own "know-how" in selecting candidates for this training (Schofield, 1962).

More generally, the recruitment and selection of candidates for training in any of the new health-related careers now being contemplated involves matters of motivation, values, aptitudes, personality, and interest patterns. These are broadly in the domain of assessment and this is a distinctly psychological enterprise. This constitutes another indirect but important avenue for psychology's contribution to health service delivery.

The manpower shortage is the most obvious constraint upon psychology's role in the delivery of health services. It is not the only one. We are restricted by the extent and validity of our tools and methods.

Diagnosis and treatment are the most prominent service functions for psychologists.¹⁶ There is no reason to be content at this time with either the number or quality of the instruments available for accurate and useful diagnostic appraisal of complex psychological problems. While the armamentarium is complex and varied, lack of adequately established validity and the absence of anything approaching professionally standardized patterns of procedure for individual assessment problems make for a lower quality of service than is desirable (Sundberg, 1961). In part, this sizable variation in diagnostic behavior reflects varying emphasis (or deemphasis) in training programs, and this in turn reflects a dissatisfaction with existing instruments.¹⁷

Partly out of appreciation for the limited utility of our tests, partly out of motivation to get on with the apparently more challenging tasks of therapy, and partly out of misperceptions of the pertinence of the "medical model," there has been a general neglect of our diagnostic responsibilities (Sarason & Ganzer, 1968). If we continue for long to abrogate our responsibilities in this area we shall seriously retard very much needed advances in this uniquely psychological service function. There is a need for a closer dialogue between clinician-

diagnostician and the psychometric theoretician than presently exists. Our practice in test construction, test revision, and test application seems to lag behind our theoretical and technological advances.

Our role in treatment is perhaps less than optimal to the degree that psychologists have, until very recently, been more concerned to demonstrate their right to treat than to produce evidence that their therapy was at least clearly as effective if not superior to the interventions of other professionals. With the exception of operant conditioning and the techniques for behavior modification we have not been able to deliver therapeutic services that are uniquely psychological. While our contributions as therapeutic conversationalists are not insignificant and are part of the service delivery role, they are likely to prove of considerably less value to society in the long run than contributions evolving from our expertise in the study of complex behavior and from our fundamental commitment to critical evaluation.

5. PERSPECTIVES

Psychology as a life science subsumes investigations, discovery, principles, and practices that qualify a significant portion of its endeavors as health-related science. It qualifies today as a health profession by virtue of the fact that a large portion of its practitioners are applying psychological technique and knowledge to study and treatment of a major health problem, that is, mental health. But the total of psychology's investment in delivery of health service—viewed either in terms of numbers of persons as a portion of all health workers, or as number of health areas touched upon—is minuscule. It is likely to remain small when measured against the sum of all health services.

If the estimate of 3 million persons employed in 1965 in health professions and occupations is correct (U. S. Department of Health, Education and Welfare, 1965), the *total* membership of APA would constitute less than 1% of that pool. It would constitute less than 3% of the total of primary health service deliverers, such as physicians, dentists, and nurses. Actually, only one-fifth of APA's 27,000 members identify themselves with the specialties (clinical, counseling, and school psychology) having greatest commitment to direct service. As far as these psychologists are concerned,

¹⁶ It may be argued that consultation is a more important activity than either diagnostic evaluation or remedial intervention and that consultation is a form of service. As such, however, consultation is indirect and must be considered apart from direct delivery of service to the client.

¹⁷ While medicine, by virtue of the nature of the variables it deals with, can and does have better instrumentation and a relatively more reliable "laboratory," it is not free of the problem of the unstandardized practitioner (Peterson, 1956).

psychology is not presently a significant supplier in numbers of a variety of health workers to the American public. As long as our head count is of persons *eligible* and *motivated* to be members of APA, there is no expectation that the most readily visible group of American psychologists will constitute a large part of the health service pool.¹⁸

We measure manpower because it is readily measurable. Such numbers do not express amount, quality, or significance of product. The import of psychology's contribution may be immeasurably large in terms of human welfare. How does one measure the worth to the individual, and to society, of intervention that prevents a psychotic break or lengthy hospitalization? Even such direct service is likely always to constitute the lesser of psychology's contribution. It is in the potential of its research over the entire domain of illness that we are likely to find psychology's most important contribution.

Psychology is presently anemic vis-à-vis the other health professions; we are weak in numbers and in technology—applied method soundly based on basic knowledge. We may become robust. Whether psychology achieves a more significant and productive role as a health profession depends in part on the decisions (and interests) of individual psychologists. A decision, implemented by the coordinating and facilitating resources, of our national organization to become (or not to become) more broadly and effectively based as a health profession has been prevented so far by inconsistencies and insecurities.

Our inconsistency, as clearly pointed out by Brayfield (1966), has been epitomized in the two "white papers" of 1966. "The community mental health center paper espouses a non-medical model and casts doubt on individual psychotherapy as a major approach; the insurance paper essentially accepts the medical model and the utility of one-to-one psychotherapy."¹⁹ A rare example of two not quite pure whites mixing to produce a very

¹⁸ We must recognize that such a census of deliverers of psychological services is far from comprehensive; there are many persons who, despite psychological training and practice (e.g., many vocational counselors), may not identify themselves as "psychologists" or seek APA membership.

¹⁹ Our demand to have psychotherapeutic services covered under comprehensive medical insurance has some ethical implications for our work and for our clients that have not been generally appreciated (Simon, 1967).

definite gray! Is it entirely cynical to observe that "a profession is a conspiracy against the laity"?²⁰

Our insecurities are exemplified by our approach-avoidance neurosis in regard to subdoctoral training. As long ago as 1955 it was said, "The conclusion that subdoctoral training must be provided seems unavoidable [Strother, 1956]." That conclusion has never been factually refuted (APA, 1959; APA Education and Training Board, 1955; Clark, 1957; Hoch et al., 1966; Kelly, 1950). The obvious implication of such a conclusion, that we should establish some reasonably numerous and varied subdoctoral programs with appropriate controls and provisions for evaluation, has never been implemented under the official aegis and blessing of APA.

Voices of caution, of reservation, of fear, and of sheer disinterest have prevailed. This has not been a matter of simple antiphony—the academicians versus the clinicians, the scientists versus the practitioners. Actually, some "basic science" types have shown more reality contact than many of their clinical brethren (Verplanck, 1966). The reluctance of academic department heads to mount subdoctoral programs is due in part to the fact that their own clinical staffs have rarely spoken in unity on this issue. Many PhD clinicians appear to be threatened by the proposal of subdoctoral workers. If this is because they perceive with respect to the function they choose to pursue that their training has given them very little if anything more than could be contained in a solid MA curriculum, they should be threatened. In the concern for reserving the title "psychologist" to holders of the doctorate, they reveal the same insecurity and self-sanctification that they deride in the physician who argues that only MDs are "real" doctors. Respectability is being valued over responsibility.

Our delivery of more and better service rests upon the development of greater knowledge and improved technology. This requires research—more and better research. To achieve this may require a sizable revision of the training for our most service-oriented specialties—clinical, counseling, and school psychology. It would seem that the research and science portion of our doctoral programs have been generally inferior to the clinical and service portion, and that we have selected students inappropriately for PhD training in clinical psy-

²⁰ George Bernard Shaw, *The Doctor's Dilemma*.

chology. Surveys of the job satisfaction and research activity of PhDs trained in the Boulder model indicate that they are neither content nor productive (Kelly & Goldberg, 1959; Levy, 1962). Yet, our most recent national conference on the professional preparation of clinical psychologists "actually underscored its continuing endorsement of the scientist-professional pattern [Hoch et al., 1966]." Possibly one of the more clearly unfortunate results of our adoption of the "medical model" has been our rigidification of professional curriculum and standards for accreditation. Medicine, with a much longer history, is only now showing signs of significant innovations in the medical curriculum, as well as considerations of the need for and possible roles of "subdoctoral" physicians. Is it going to take us equally as long to effectively implement our present recognition that the PhD model is inadequate to society's needs?

We need to increase the amount and improve the quality of our research activity in health-related areas. There is evidence that increasing the number of PhD clinical psychologists à la Boulder will not have this result. Such individuals apparently are lacking in time, talent, or motive. They would have more time for research if they had more help, through qualified assistants, with the heavy clinical burden of cases demanding diagnostic study and intervention. They would reveal more drive for research if they were more carefully selected for *research* interests rather than clinical service values. They would reveal more research talent if their graduate programs were not top-heavy with requirements for the acquisition of clinical skills. Obviously, a significantly improved role of psychology as a health science is not likely to be realized unless and until we undertake a rather thorough overhaul of our professional degree programs, including the introduction of subdoctoral training.

Having reviewed the manner in which psychologists are presently engaged in the health enterprise and the nature of new demands for their help, it is appropriate to review explicit policy of our national organization as it relates to such engagement. The following quotes are all drawn from APA's (1968b) recently revised and approved statement of American psychology's professional principles:

Like other professions, American psychology is a social entity operating in a supporting society. . . .

Psychology has three major purposes: to increase the body of knowledge in its content area, to communicate this knowledge, and to apply it in a socially useful and responsible manner. . . .

The American Psychological Association, as the official national organization of psychologists functioning in all of their specialties, accepts responsibility for coordinating the development and functioning of psychology as a profession. In this role the Association is guided primarily by general criteria of human welfare. . . .

Psychologists accept the responsibilities for: . . . endangering in aspirant members of the profession and displaying in their own practice a keen sense of social responsibility; employing available psychological knowledge for the enhancement of human effectiveness and the betterment of human welfare. . . .

The American Psychological Association believes it is undesirable to attempt to control the practice of all psychological functions by restricting them to members of any single profession except insofar as it can be clearly demonstrated that such restriction is necessary for the protection of the public. The Association's policy, therefore, is to oppose restrictive legislation or administrative policies which provide that only psychologists (or teachers, or physicians, and any other designated professional group) may engage in applications of certain knowledge and techniques of their field. . . .

As members of a good profession, psychologists: 1. Guide their practices and policies by a sense of social responsibility; 2. Devote more of their energies to serving the public interest than to guild functions and to building in-group strength. . . .

Since the close of World War II, psychology clearly has operated in a supporting society—supporting but not demanding. Through the United States Public Health Service, the National Institute of Mental Health, and the Veterans Administration, our society's needs for psychological service, largely clinical, were communicated to the universities and, in collaboration, the academic departments of psychology and the Federal agencies designed educational and training programs for new psychological professions—the clinical psychologist and the counseling psychologist. The APA, in collaboration, established a mechanism for evaluating these programs and maintaining high standards.

Society has supported all of these efforts and has trusted the judgment of experts in the design of the models. The responsibility for the content of training programs rested largely, and with minimal interference, within academic psychology. Emphasis has been on a rigorous academic-profes-

sional program with a high quality product at the doctoral level. It was expected that the PhD scientist-practitioner would contribute both to clinical service needs as well as to advancement of basic knowledge, the improvement of existing techniques, and the discovery of new methodology. Failure with respect to the latter expectation has been adequately documented (Levy, 1962).²¹

The architects of the "Boulder model" could not know the full extent of the demand for clinical psychological services, the rate of increment of that demand with the revivification of the mental health movement in the postwar period, the increased variety of need with the development of the concepts of social psychiatry, community psychology, and the comprehensive community health center. There is nothing inherently wrong with the scientist-practitioner model as a paradigm for the education and training of persons who are to provide leadership in research and practice and serve as teachers and supervisors of students and clinicians. There is a continuing need for the products of such doctoral programs. But they are simply inadequate in number to meet society's service demands.

The APA has functioned responsibly and effectively in guiding the development of the clinical branches of professional psychology so as to serve and protect human welfare. Will it continue to do so? Society is still supporting, but it is becoming more demanding. At all levels of Federal and state governments, agencies concerned with the general well-being of individuals are beginning to look to psychology for more service, for better service, for different kinds of service. Will the establishment of psychology be responsive and truly socially responsible? Will it be content to continue to concern itself primarily with "guild" functions and to building in-group strength—as was absolutely necessary during the past two decades? Or will it provide the leadership, instigation, and initiative in coordinating the talents, resources, and knowledge of psychology and communicating these through appropriate channels so that the potential contribu-

tion of psychological science to the total health enterprise may be fully realized?

APA is opposed to restrictive legislation as it would inhibit the opportunity of thoroughly professional psychologists to offer their unique services to the public. But in its official position on licensing of psychologists, it does not favor legislation that would permit persons trained appropriately and competently at less than the doctoral level to offer independent services to the public (APA Committee on Legislation, 1967). Where is our manifestation of social responsibility and our concern for human welfare in this restriction of practice?

Have we succeeded in engendering in our members "a keen sense of social responsibility" and a devotion of "their energies to serving the public interest"? The manner in which clinical psychological services are purveyed is relevant to this question; a recent survey of fee practices and schedules provides some data (APA Board of Professional Affairs, 1968).

1. One-third of the APA members with state certification were asked to provide questionnaire data—only 57% responded!

2. Of the 1,515 respondents, 44% indicated they were in solo practice, 69% reported responsibility for setting their own fees, 42% indicated an increase in their fees during the previous 12 months.

3. Nearly half of the respondents (48.7%) reported they did not use a fee rate based on the income of their clients.

In the process of standardizing the training and legal qualifications of professional psychologists, largely by aping the medical establishment, have we indirectly supported a solo private-practice, laissez-faire, what-the-traffic-will-bear, *caveat emptor* approach to the dispensation of services—an outdated model that now shows increasing signs of morbidity within the medical profession (Shakow, 1968)?

It is no longer a question of fighting for a place at the table. We are accepted there. But our continued presence will demand justification in terms of our day-to-day contribution. If we wish to eat at society's table, we must be able and willing to till society's fields.

²¹ Reference here is to solid research with implications for professional practice and significant social impact. Most of this has come from a handful of persons, most of these "grandfathers." The plethora of publication in the realm of psychotherapy is for the most part neither innovative nor evaluative.

In psychology's laboratory, which effectively encompasses the world of behaving organisms, the psychologist qua scientist wants to understand better, the psychologist qua professional wishes to do better. There is a patent interdependency of science and profession. In psychology to date, this interdependency is an unachieved ideal: our scientists offer less than they might; our practitioners apply less than they should. A lack of unity within our house seriously obstructs the potential contribution of psychology to the development of a society of individuals who are healthier in *all* respects.

A number of trends converge at this time to make it propitious for American psychologists, and their national association, to examine their current activities and programs and in particular the patterns for graduate education in psychology with a special view to the varying demands for psychological services. These trends include the increasing influence of scientific advances on health care, the changing composition of the population especially in respect to age, the increasing demand by individuals for more and better health care, the decreasing role of independent noninstitutionalized private practice in the provision of health care, the need for increasing numbers of health personnel, and the expanding interest of government in the efficient and economical supply of health services. In a major report on the implication of these trends for medical education, the risks of inaction are stated succinctly, and they apply equally to psychology:

If action is not taken by those best equipped to plan and implement changes—the persons now responsible for medical [read psychological] education—action will be sought by the public at large and the initiative for action will be assumed by forces less well equipped [Coggeshall, 1965].

Psychology now occupies a rather restricted position as a health profession, a position manifested primarily by those persons identified as "clinical psychologists." While this position may not be impressive either in numbers or prestige, it is well established in the matrix of public demand and legislative response. We probably could not (and certainly should not) withdraw from this service delivery role despite the conflicts, insecurity, and frustrations that presently surround it. Should we decide as a matter of general policy to reserve our health-service role to the clinical field as presently

defined, we have a continuing responsibility to be concerned with the quality of that service and the adequacy of its supply.

There is a new concept of health care and health service now being promulgated by those governmental offices responsible for protecting and improving the general well-being of the population. They are no longer content simply to care for victims or content beyond that to prevent injury and illness. The new concept is more positive in orientation—it seeks to assure that every individual will be able to realize his full physical, psychological, and social capacity. It encompasses prophylaxis, prescription, and potentiation.

If this new concept is to be realized there must be planning and implementation of a broad range of personal and social services. Whether a particular program is primarily preventive, remedial, or instructive, whether its clients are infants, children, adolescents, or senior citizens, normals or deviates, whether its target is physical, mental, social, or economic health—it is almost certain to entail psychological processes and psychological problems. It is the early recognition of this fact that leads already to burgeoning demands for the talents and energies of psychology.

Organized psychology—the "invisible" consortium of academic departments and the national association of member psychologists—must acknowledge the existence of these demands. It must examine them critically. Then it must decide whether or not it wishes to be effectively and organically engaged in this new social undertaking.

The individual psychologist, following the dictates of his conscience and the pulls of his professional interests, may or may not see and grasp opportunity to contribute to the health endeavor. But if psychology is to have significant impact and if its opportunities for new discovery and new testings of its concepts are to be realized, there must be a reasonable degree of commitment and dedication of the profession at large.

In order to examine the issue, "Should psychology become a broadly based health profession?" it will be necessary to know not only the variety and extent of opportunities now opening to it, but to know also in detail the variety and extent of current psychological activities in the health field. It is not sufficient to know how many self-identified "clinicians" are doing how much clinical practice.

There must be detailed information on the *specific* teaching, research, and clinical activities of all psychologists associated with all branches of the health enterprise.

If the examination of new service opportunities in the light of present resources (persons and technology) and social responsibility leads to a decision that psychology should develop a broader stance as a health profession, it will be imperative to undertake our own detailed appraisal of present and future manpower. In this endeavor, as it relates to recruitment potential, we must pay more attention to the questions of individual value structures, interest patterns, and motivation (and perhaps relatively less to sheer academic aptitude) than we have in the past.

No consideration of manpower can be independent of the design of educational programs. We have an advantage in the several and extensive forums on professional and scientific training already documented. We do not need to repeat any of these but rather to set a few of our wisest persons to a thoughtful analysis of the recurrent agreements and caveats of these forums and their attendant implications.

A final thought. Status will almost certainly not be quo. We might decide (and wish) that we be allowed simply to go on with our presently established and circumscribed role as a limited health profession. We are unlikely to be permitted that option. Our decision, upon careful review, will result in action or inaction—and we will either move ahead or regress.

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Dr. LITTLE. Practicing clinical psychologists are qualified by training and experience to provide diagnostic and treatment services to persons with emotional and mental disorders. Forty states now have laws regulating psychological practice. The remaining 10 states and the District of Columbia have non-statutory certification established by the state psychological associations. In addition, psychologists are bound by a quite detailed code of ethics that is strictly enforced by our national association.

THE ROLE OF THE PHYSICIAN

Part A of the medicare law covers services rendered by a psychologist to in-patients at psychiatric facilities. But Part B of this law allows the out-patient services of a psychologist to be covered only when they are "incident to a physician's services."

This restriction, which applies equally to psychotherapeutic and diagnostic psychological testing services, imposes an undesirable and unnecessary constraint upon the delivery of mental health services and upon the fullest and most economical utilization of scarce mental-health manpower. Qualified psychologists are unlikely to be employed in the offices of private physicians in any significant number, and the clinics in which they serve are not always directed by a physician.

In amending the Social Security Act, the 90th Congress directed the Secretary of Health, Education, and Welfare to study the desirability of expanding medicare legislation to cover the services of independent practitioners other than physicians. This study was carried out by Secretary Wilbur Cohen, who filed a report with your committee in January 1969. The report, entitled "Independent Practitioners Under Medicare," recommended the expansion of Part B to include psychologists practicing in HEW-approved facilities, but it also recommended that the physician continue to control the treatment of all medicare patients, including those with mental, emotional, and behavioral disorders.

Our association took strong exception to that conclusion in an official statement sent recently to Secretary Finch. I wish to reaffirm our position to your committee.

THE ROLE OF THE PSYCHOLOGIST

The Cohen report does not question whether psychologists have the training and ability to make their contribution to the care of the aged. But the report does not follow this conclusion to its logical end to permit psychologists the autonomy which their profession deserves. This recommendation is particularly unfortunate, for physicians by training and experience are generally less qualified than psychologists to detect and treat emotional and mental disorders, whether or not these disorders are connected with a physical illness.

The Association is well aware of the argument that a psychologist, if not under the direct supervision of a physician, might undertake treatment for which he is not qualified or might fail to refer his patient to a physician for treatment of possible medical ailments. Such concerns are groundless. The professional responsibility of a psychologist requires him to seek consultation or recommend referral when

faced with a condition, or the possibility of a condition, which is outside his own area of competence.

I want to emphasize that of the 40 states that have laws regulating psychological practice, none requires the control of conditions of psychological practice by another profession. In addition, six states have newly passed amendments to their insurance codes mandating the recognition of psychologists' services for relevant conditions covered by health insurance contracts without the requirement of physician referral or control.

The time is long overdue to replace the traditional ways of providing health care with more effective approaches. Out-patient care can no longer be safely thought of in the traditionally narrow sense of multiple office visits to the doctor and the all-too-easy dispensation of drugs. Neither the present provisions of Part B nor the Cohen recommendations recognize that for many elderly patients a sophisticated blend of psycho-social and biomedical approaches would constitute the treatment of choice.

CONTRIBUTIONS OF PSYCHOLOGISTS

Let me list for you a few of the contributions of psychologists to the out-patient care of the elderly that go unutilized or underutilized because of this restriction:

1. Early intervention in hidden depressions associated with various aspects of aging, ranging from problems associated with retirement to those stemming from the fact that elderly persons just don't have the get-up-and-go they used to have.

2. Counseling services to elderly persons whose attempts to cope with the aging process may give rise to physical ailments.

3. Group therapy, behavior therapy, and other behavior modification techniques that may be more appropriate to elderly patients than extended psychoanalytic treatment.

4. Brief intensive counseling or psychotherapy related to specific problems, such as adapting to new living arrangements, increased isolation, and suddenly increased leisure time. In this connection, I might note that there already is evidence from studies of other patient populations in both the United States and in Britain that the availability and utilization of brief psychotherapeutic assistance materially reduces utilization of medical facilities by such patients.

5. Early detection by means of psychodiagnostic techniques of impairments in intellectual functioning and motivation beyond those usually encountered in aging persons.

6. Mental health consultation, community consultation, and other psychosocially relevant interventions designed to help elderly persons bring a maximum degree of self-sufficiency and self-esteem into this final period of their lives.

A REMEDY IS NEEDED

As I hope I have made clear, the public interest is not served by the present provisions of part B. They restrict the patient's direct access to services, and thus, add to the cost. They curtail the already limited sources of help.

This deficiency in the present medicare program should be remedied in such a way that psychologists are accorded a full and independent place in meeting the out-patient needs of elderly patients.

I appreciate the opportunity to appear here today to discuss these matters of mutual concern. I will be happy to clarify my remarks now or at a later time.

The CHAIRMAN. We thank you, Dr. Little, for your statement and also for bringing these gentlemen with you to the committee.

Are there any questions?

If not, again we thank you, Dr. Little.

Dr. LITTLE. Thank you.

The CHAIRMAN. Mr. Pratt, please come forward. If you will identify yourself for our record, we will be glad to recognize you, sir.

STATEMENT OF CHARLES O. PRATT, WASHINGTON GENERAL COUNSEL, NATIONAL ASSOCIATION OF NATUROPATHIC PHYSICIANS

Mr. PRATT. Mr. Chairman, I am Charles Orlando Pratt, an attorney practicing law in the Federal court. My home is Arlington, Va. I am here today to represent the National Association of Naturopathic Physicians.

The association by its president has prepared a statement directed to John M. Martin, Jr., chief counsel, Committee on Ways and Means. I would appreciate the opportunity to read this statement by John W. Noble, president of this association, which is only a page and a half, and a brief statement written by me on behalf of the National Association of Naturopathic Physicians, which I prepared on their behalf for this purpose.

I now read the statement written by Dr. John W. Noble addressed to Mr. Martin: [Reading]

The following brief was submitted in 1968 to the Ad Hoc Committee, Department of Health, Education, and Welfare, with a recommendation that naturopathic physicians be included in the Federal Medicare Plan.

Attached to this statement is an outline for study of services of practitioners performing health services in independent practice, dated August 1, 1969, and submitted by the National Association of Naturopathic Physicians. [Reading]

The brief was prepared by the National Association of Naturopathic Physicians for use by the Committee in its study to determine the feasibility of including the services of licensed practitioners performing health services in independent practice (Part B of Title XVIII of the Social Security Act).

Since the Ad Hoc Committee attacked the validity of naturopathic philosophy and did not adhere to its original purpose of studying the cost and feasibility of adding other types of practitioners to the Social Security Act, the N.A.N.P. is, at this time, submitting the original brief to the Committee on Ways and Means, U.S. House of Representatives for use during the public hearings on Social Security and Welfare proposals which began October 15, 1969.

Right here, Mr. Chairman, I would like to ask you for the privilege of presenting this statement by the president and this outline as part of the record.

The CHAIRMAN. Without objection, it will be included in the record. (The documents referred to follow:)

NATIONAL ASSOCIATION OF NATUROPATHIC PHYSICIANS,
Portland, Oreg., October 31, 1969.

Re proposal relating to medicaid and medicare.

Mr. JOHN M. MARTIN, Jr.,
Chief Counsel, Committee on Ways and Means,
Washington, D.C.

DEAR MR. MARTIN: The following brief was submitted in 1968 to the Ad Hoc Committee, Department of Health, Education, and Welfare, with a recommendation that naturopathic physicians be included in the Federal Medicare Plan.

The brief was prepared by the National Association of Naturopathic Physicians for use by the committee in its study to determine the feasibility of including the services of licensed practitioners performing health services in independent practice (Part B of Title XVIII of the Social Security Act).

Since the Ad Hoc Committee attacked the validity of naturopathic philosophy and did not adhere to its original purpose of studying the cost and feasibility of adding other types of practitioners to the Social Security Act, the N.A.N.P. is, at this time, submitting the original brief to the Committee on Ways and Means, U.S. House of Representatives for use during the public hearings on Social Security and Welfare proposals which began October 15, 1969.

In other words, we feel that the Congress has been denied access to the contents of the brief which took us almost six months to compile. We stand on the statement as originally drafted as nothing materially new has transpired since then to chance its content.

Mounting evidence now exists that the gap between the application of professional skill and the urgent need for such service is more real than was suspected and it is the opinion of many interested citizens that the inclusion of other types of licensed practitioners in the Supplementary Medical Insurance program of the Social Security Act would be of immediate benefit in bridging the gap.

According to the American Medical News for October 13, 1969, health manpower and health services are absolute top priorities in the health care field and Secretary Robert Finch of the Department of Health, Education, and Welfare, is especially enthusiastic about using returning Vietnam medical corpsmen to augment the hard-pressed physician in reducing the serious shortage of doctors.

In a recent interview with reporters from the U.S. News & World Report of November 3, 1969, Dr. John A. D. Cooper, President, Association of American Medical Colleges, pointed out that President Nixon, in presenting a White House report on health-care needs, said there was a severe crisis in health-care delivery, and that part of this crisis was lack of an adequate number of physicians and other manpower in this field. President Nixon further stated that unless corrective measures are taken, we face a complete breakdown in the system in two or three years.

The National Association of Naturopathic Physicians feels that the inclusion of other types of licensed practitioners in the Social Security Act would help close the gap between the lack of skilled service and its application to the needs of the elderly citizen of the United States.

Since the minority groups in the health care field offer *alternative* service, rather than additional service, it is unlikely that the addition of these practitioners to the Social Security program would entail any additional cost to the administration of the program.

Your courtesy in considering our request is greatly appreciated.

Sincerely,

JOHN W. NOBLE, N.D.

OUTLINE FOR STUDY OF SERVICES OF PRACTITIONERS PERFORMING HEALTH SERVICES
IN INDEPENDENT PRACTICE

I. Organization: National Association of Naturopathic Physicians

A. STRUCTURE

1. Historical development

Naturopathic medicine embraces several state and national bodies, plus a semi-active international organization.

The national history of naturopathic organization runs through varied names, titles, and leadership—all concerned with what has been virtually the same basic on-going association.

The present National Association of Naturopathic Physicians was formed in 1956 by merging two foregoing groups—the American Naturopathic Association and the American Association of Naturopathic Physicians. The present N.A.A.P. is today's single most comprehensive naturopathic society, albeit there is a relatively inactive International Society of Naturopathic Physicians.

Headquarters of the National Association of Naturopathic Physicians is at 1920 North Kilpatrick, Portland, Oregon 97217. Its President is John W. Noble, N.D. Arno Kogler, N.D., of 22 McDougall Avenue, Waterloo, Ontario, Canada, is President of the International Society of Naturopathic Physicians.

2. Official purpose

The N.A.N.P. exists to strengthen and conserve public health through the philosophy, art, science, and practice of naturopathy (see Article II of the appended Constitution of the N.A.N.P.)

3. Regional, state, and local affiliations

Article I of the appended N.A.N.P. By-Laws authorizes the affiliation with N.A.N.P. of local associations under these conditions:

Section 1. Any state or territorial association wishing to become a constituent association of the National Association of Naturopathic Physicians shall make application on a prescribed form and submit evidence that its Constitution By-Laws, and Code of Ethics conform generally to those of this Association.

Section 2. It shall be a condition of such affiliation on the part of the constituent associations that the work of the officers, boards, departments, councils, bureaus, and committees of this Association will receive the cooperation of the constituent associations through their corresponding agencies.

Section 3. It shall be the duty of the Executive Committee to investigate and act upon all applications for affiliation as constituent associations, and pursuant thereto it may issue a charter to those whose Constitution, By-Laws, Code of Ethics, and general plan of operation conform in substance with those of this Association. The Executive Committee shall not issue more than one charter within the same state or territory.

There are at present formal state associations affiliated with the N.A.N.P. in Oregon, Idaho, Washington, Kansas, New York, Connecticut, and California.

4. Sources of income

N.A.N.P. income is derived from membership dues, paid annually—(\$12 for each member of a local association and \$20 for each individual (non-member of a local association) N.A.N.P. member); from educational seminars, and from proceeds from conventions when such meetings realize a profit. Currently, N.A.N.P. is planning publication of a professional journal and its advertising profits will revert to the N.A.N.P. treasury.

5. Staff

N.A.N.P. does not maintain a paid staff. Its elected officers perform its organizational work. They are a President, Vice-President, Immediate Past-President, Treasurer, and Secretary—comprising the N.A.N.P. Executive Committee, plus nine Trustees, also elected. These two groups of officials comprise the administrative (policy-making) and judicial (disciplinary) executive echelon of the Association.

The current officers are:

President: John W. Noble, N.D., 1920 North Kilpatrick, Portland, Oregon 97217.

Vice-President: John B. Bastyr, N.D., 735 - 10th. Avenue, E., Seattle, Washington 98102.

Immediate Past-President: Douglas E. McArthur, N.D., Seaboard Building, Seattle, Washington 98100.

Treasurer: Henry Linke, N.D., 320 Main Street, Kellogg, Idaho 83837.

Secretary: Dorothy Johnstone, N.D., 6005 S.W. Capitol Highway, Portland, Oregon 97201.

Trustees are:

Arizona:

Michael Lunch, N.D., 15 Leroux, Flagstaff, Arizona 86001.

Donald R. Bettner, N.D., 1137 W. McDowell Road, Phoenix, Arizona 85006.

Colorado: Robert E. Bock, N.D., Box 61, Monte Vista, Colorado 81144.

Idaho:

Wendell M. Grout, N.D., 827 Main Avenue, W., Twin Falls, Idaho 83301.

A. J. Hahn, N.D., 710 S. Orchard, Boise, Idaho 83705.

Indiana: F. C. Albrecht, N.D., 627 S. Main Street, Crown Point, Indiana 46307.

Oregon: Charles R. Stone, N.D., 304 Postal Building, Portland, Oregon 97204.

Washington:

Walter Adams, N.D., 412 E. 72nd. Street, Seattle, Washington 98115.

Robert V. Carroll, N.D., 318 Shafer Building, Seattle, Washington 98101.

The officers named above will serve through mid-August, 1968. The Trustees serve three-year, staggered terms, with three seats becoming vacant and subject to being filled electively each year during voting at the annual N.A.N.P. convention.

Qualifications for holding the above-named offices will be found in Articles V and VI of the appended N.A.N.P. Constitution.

6. Membership

a. Individual members

Members of the N.A.N.P. and its affiliated associations are licensed naturopathic physicians—N.D.'s: or dually-licensed naturopathic physicians and chiropractors—holding both N.D. and D.C. degrees; or chiropractic physicians practicing in states which do not license naturopathic physicians per se—practitioners who nonetheless diagnose and treat patients under the principles of naturopathic medicine, hence meet the membership standards of N.A.N.P. In several states without licensing statutes pertinent to naturopathy, naturopathic physicians are registered, thereby again obliging membership standards of N.A.N.P.

In reciting membership statistics, we should emphasize that this questionnaire is not being completed and filed solely on behalf of practitioners who are N.A.N.P. members. Rather, it is aimed at advancing arguments for and defining the professional posture of *all* men and women who practice as naturopathic physicians in the United States.

It is estimated that there are in the United States, under the three above-cited conditions of practice, 3,000–4,000 practicing naturopathic physicians. Because of the varying conditions affecting licensure, regulation, registration, or the common law right to practice, we cannot offer a precise head-count, but we believe that the total number of active and inactive naturopathic practitioners in the United States today would break down in approximately these numbers:

New England	350
Middle and southern Atlantic coast	650
Chicago-Great Lakes area	600
Southern middle west	750
Southwest, including California	1,500
Northwest	850
Total	4,700

Current (mid-1968) membership of N.A.N.P. by state association breaks down this way:

Oregon	20
Washington	26
Idaho	26
Kansas	16
New York	7
Connecticut	24
California	17
Individual members, not affiliated with a local association	32
Total	168

(Canadian membership is not included, as these practitioners would obviously not be concerned with applications of U.S. laws.)

b. Individual membership qualifications

Continuing the points made as a necessary prelude to answering I.A.6.a., above, naturopathic physicians are specifically licensed or registered in fourteen states and the District of Columbia: licensed in Washington, Oregon, Arizona, Utah, Florida, Connecticut, Hawaii, Virginia, Ohio, Pennsylvania, and the District of Columbia; registered in California, North Carolina, New York, and Kansas (and practicing under common law in Idaho).

Most states with licensing statutes require two years of pre-naturopathic college in liberal arts or science. In addition, all states require four-year, in-residence study in an approved naturopathic institution, with a total classroom instruction of 4500 hours (a median figure—requirements range from 4000–4800 hours).

(Parenthetically, by defining requirements for licensure or registration, we are also defining requirements for membership in the N.A.N.P., the questionnaire's specific point of inquiry.)

Many states have enacted statutes requiring that applicants must pass a basic science examination administered by the particular state's Board of Higher Education before being examined by a naturopathic examining board.

In states with no specific naturopathic licensing laws, most often registries of practitioners are maintained. . . . registration under some other type or term of licensure, or without any license in some cases. Registries exist in states in which there is no formal N.A.N.P.-affiliated association. States which now maintain such registries include California, New York, Kansas, and North Carolina. . . . to our knowledge. We have appended California's registry as a sample.

The most succinct body of data on naturopathic licensing is contained in "State Licensing of Health Occupations", U.S. Department of Health, Education & Welfare, Public Health Service, National Center for Health Statistics—Public Health Service Publication No. 1758, of October, 1967; pp. 61, 62, 63.

To become a fully qualified, active member of N.A.N.P., a practitioner must meet membership requirements set forth in the appended N.A.N.P. By-Laws; Article II and III.

Associate members of N.A.N.P. are those persons without a Doctor of Naturopathy degree but who carry on natural healing activities within the limits of state and federal law. Acceptance (most often via state registry) of persons in this category does not confer a degree or license upon the individual, obviously, but acknowledges and affirms the legality of the work they are doing and records their practice statistically. Among the N.A.N.P.'s associate members (by registry) are many chiropractors and physiotherapists, most of whom work closely with naturopathic physicians.

c. Dues

See Article III of the appended N.A.N.P. By-Laws.

B. ACTIVITIES

1. Approval programs

Licensing and/or registration as a naturopathic physician by entities of government have been described in the above I.A.6.a. and b.

Regarding approval for membership in the N.A.N.P. and/or its affiliated associations, Article I of the appended By-Laws contains the stipulation that no state association or society or chapter (whatever its nomenclature) shall be accepted for N.A.N.P. membership unless the applying group makes application on an N.A.N.P.-prescribed form or submits other evidence that its own membership requirements, Constitution, By-Laws, and Code of Ethics conform generally to those of N.A.N.P.

It follows that individual practitioners or applicants for associate membership must likewise agree to conform to N.A.N.P.'s stipulated guidelines for professional conduct.

a. Personal members

Single practitioners must meet the minimal membership requirements of local N.A.N.P.-affiliated chapters, whose membership criteria must in turn meet N.A.N.P. conditions.

Members of N.A.N.P. are subject to the same re-approval of their membership as licensed practitioners are subject to suspension-of-license or revocation procedures in states with licensing statutes. N.A.N.P. and its affiliated chapters

maintain intra-professional boards or committees empowered to hear public grievances and/or intra-naturopathic grievances against practitioners who violate the profession's state or national organizational Codes of Ethics. Likewise, state boards of examiners or other licensing or administrative agencies are empowered to review, suspend, revoke, and/or renew naturopathic licenses.

The N.A.N.P.'s current Code of Ethics, adopted in 1960, is appended.

b. Health care institutions

Naturopathy is primarily a single-practitioner profession. Some practitioners share practice with a colleague; a few have initiated specialized clinical practices (which were common prior to World War II). Because naturopathic physicians predominately treat patients in their offices or in patients' homes albeit many rest and convalescent homes admit naturopaths to care for patients in those facilities), no N.A.N.P. screening of institutions has been initiated. There are no solely-endowed naturopathic hospitals or similar facilities, hence criteria for evaluating such facilities have not been developed.

c. Educational institutions

In major heading IV, to follow, this subject is dealt with more comprehensively.

At present, the sole active and approved four-year college for the study of naturopathy is the National College of Naturopathic Medicine, legally headquartered at 1920 North Kilpatrick, Portland, Oregon 97217, but presently conducting classwork at 1327 North 45th Street, Seattle, Washington 98103. The college's President is Maxwell H. Morris, Th.D., at the Seattle address. The President of the college's Board of Trustees is Fred Loffler, N.D., 175 East Broadway, Vancouver 10, British Columbia, Canada. The Registrar is George Rom-bough, N.D., at the Seattle address.

The College is approved by N.A.N.P. and the Canadian Naturopathic Association. It is approved for training veterans under Public Law 550 and is certified to educate eligible veterans under Oregon's Veterans' Aid Act. The U.S. Department of Immigration has placed the College on its list of colleges and universities approved for the admittance and education of foreign students. A diploma from the College is recognized by State boards of examiners in all licensing states, and in Canada.

Administrative control over the College is vested in an elected Board of Trustees and the College President, Dean, and faculty. The College is owned by the Naturopathic Physicians Educational Foundation, organized under Oregon law as a non-profit corporation.

Current President of the Foundation is B. A. Smith, N.D., 870 Garden Valley Blvd., Roseburg, Oregon. Current Secretary-Treasurer is Lloyd Rapp, N.D., 103 North Umpqua, Sutherlin, Oregon.

2. Meetings

N.A.N.P. calls and holds annual membership meetings, at times and places set by its Executive Committee or as determined by membership vote at the prior annual meeting.

Component chapters of N.A.N.P. likewise host educational seminars and/or meetings are identical: to promulgate organizational policy and stimulate post-Naturopathic Physicians Convention of May 9-11, 1968, the program for which is appended.

The purposes of both regional-local and national naturopathic membership meetings are identical: to promulgate organizational policy and stimulate post-graduate education.

Attendance is open to any bona fide member of N.A.N.P. or its affiliated local chapters.

Seminar or speech topics at such meetings range from legal-medical to intra- and inter-professional; i.e., legal responsibilities of naturopaths to their patients, research results or practice innovations from allied health care professions, new therapeutic techniques, new botanical medicines and their application, etc.

3. Research

a. Intramural

Not having a specific research facility, naturopathy does not pursue research as an organized collective. A primary reason for the lack of collective research is under-financing; i.e., grants-in-aid and other private foundation or government funds are not being made available to this profession.

Individual practitioners and graduate students have been and are currently working in the fields of physiotherapy, nutrition, and botanical medicine . . . particularly in relation to the management of chronically ill and geriatric patients. Likewise, N.A.N.P. committees on technique evaluation, physiotherapy analysis, and the management of orthopedic problems are currently at work in conjunction with faculty of the National College of Naturopathic Medicine.

b. Extramural

Possibly much of the research we refer to above falls into the category "Extramural" . . . as being "outside . . . the walls . . . of an organized unit" (to cite Webster's definition).

In essence, the N.A.N.P. nurtures and encourages research, but cannot finance it on its own. N.A.N.P. can and does recognize intra-professional research by soliciting monographs for its seminars and for the publication "The Naturopath", which will be described more fully below.

a. Purpose

The N.A.N.P. is currently completing plans for publication of a quarterly "Journal of Naturopathic Medicine," to be first printed in early 1969, for members and the interested lay public.

Currently, "The Naturopath" is published as an instrument to circulate professional research papers by member and non-member naturopaths, news of botanical medicines and their application, and general news pertinent to health care fields allied with or germane to naturopathy.

b. Circulation

Published monthly, "The Naturopath" reaches more than 5000 doctors (allopathy, chiropractic, osteopathy, and naturopathy) and laymen. It was first published in 1962 and its most recent edition prior to this report was August, 1968.

5. Copy of the current publication list

Copies of the last 12 editions of "The Naturopath" are appended.

C. ASSOCIATION RELATIONSHIP WITH OTHER HEALTH PRACTITIONERS

1. Joint activities

In every instance where their cooperation has been solicited, the N.A.N.P. and its affiliated chapters have joined with, met with, or otherwise shared with other health care professions their body of technical knowledge.

A case in point, where formal interrelationships were involved, was the Oregon Interprofessional Health Council. In this instance, the Oregon Association of Naturopathic Physicians was a founding agency of this group, which was formed for the mutual exchange of healing arts knowledge. Naturopathy joined podiatry, chiropractic, pharmacy, veterinary medicine, osteopathy, and optometry to create the Council.

The N.A.N.P. works with every type of health care practitioner in legislative matters, urging the upgrading of all professions' standards by self-discipline and/or state or federal statute. In the several states where its chapters are operative, or in Washington, D.C. at the federal level, N.A.N.P. has worked closely with departments of welfare, industrial workmen's compensation boards, private and public rehabilitation agencies, boards of health, and other entities which deal with comprehensive health care.

Naturopathy's keenest immediate concern is with diet and nutrition, therefore the parent Association and its component chapters and members seek close relationships with dietitians, nursing in general, nutritionists, food chemists, organic chemists, botanists, horticulturists, and others concerned with man's basic sustenance: food.

2. Policies and activities endorsed

Organized naturopathy supports pure food and drug laws and their enforcement, the complete and free dissemination to all practitioners of newly-discovered techniques of treatment, and maximum inter-professional referral of patients when the specialty of an allied profession is called for.

N.A.N.P. has strongly endorsed federally endowed health care programs and equivalent private group plans. In 1961, N.A.N.P. relayed to then-President John Kennedy its unqualified endorsement of "Medicare-Medicaid" (either King-Anderson or Kerr-Mills).

N.A.N.P. endorses strongly the F.D.A. stand on "dangerous drugs" and supports state legislatures' moves to curtail their unrestricted dispensing and use. The Association supports the concept of increased federal aid to health-care students and the institutions which educate them. The Association supports efforts to lower the prices of remedial substances generally, especially for geriatric patients and pensioners.

3. Policies and activities not endorsed

N.A.N.P. opposes "fad" healing and quackery, but it likewise opposes the F.D.A. attitude concerning food supplements . . . proposals which would confine certain types of food supplements to a prescription basis. The Association is organically (i.e., "naturally") directed—therefore it opposes over-use of toxic fertilizers and other chemicals which taint our foodstuffs and which harm our national ecology and individual health.

N.A.N.P. opposes, intra-professionally, criticism of other health care professions, unprofessional advertising or conduct by its members, and racial or religious discrimination among patients.

D. CODE OF ETHICS

The N.A.N.P. Code of Ethics is appended.

1. Official association statement

The appended Code of Ethics carries within it a set of policy statements which sum-up official attitudes of the N.A.N.P.

2. Describe disciplinary procedures

Grievances or actions against practitioners can originate with (1) state boards of examiners; (2) other state regulatory authorities (where naturopathy is not licensed per se); (3) committees or governing boards of affiliated chapters of N.A.N.P., or (4) with the governing officers of N.A.N.P. itself.

In the case of the first two groups of bodies cited, suspension or revocation of a practitioner's license or legal ability to practice will also result in the N.A.N.P.'s voiding a practitioner's membership. Results of such actions by agencies of government are usually forwarded to either the affiliated chapter's officers or to N.A.N.P. itself where there is no local chapter.

Within an affiliated chapter, such grievances are heard, testimony of the aggrieved party is solicited and heard, statements by the accused practitioner are heard, and a decision is rendered.

Intra-professionally, an "aggrieved person" can be a fellow naturopathic practitioner, a practitioner in an allied health care field, an officer of N.A.N.P. or an affiliated chapter, or a layman at large.

Some disciplinary matters are not appealed to the N.A.N.P., and others come before *only* the N.A.N.P. (where a practitioner is an N.A.N.P. member, but in a state with no local chapter). N.A.N.P. is, however, bound to suspend or expel a member whom the lower, affiliated chapter has found guilty of professional misconduct, or whom a Board of Examiners has adjudged guilty. Likewise, a practitioner suspended or expelled by N.A.N.P. will not be eligible for membership in any local chapter unless and until he or she is re-accepted for membership by N.A.N.P.

Disciplinary matters can be routed from N.A.N.P. to a local society, or from a local society to N.A.N.P.—depending upon who makes the accusation and the membership status of the accused. In all instances whether either the national or a state association originates the disciplinary hearings, the results of those hearings—if culminating in expulsion or suspension—are forwarded to state boards of examiners or other regulatory authorities for their consideration and action.

II. The Discipline

A. DEFINITION

The Dictionary of Occupational Titles, U.S. Department of Labor, Washington, D.C., defines naturopathy as follows:

Doctor, Naturopathic (medical service), 0-52-21. Naturopathic. A healer. Diagnoses and treats patients to stimulate and restore natural bodily processes and functions, using a system of practice that employs physical, me-

chanical, chemical, and psychological methods; utilizes dietetics, exercise, manipulation, chemical substances naturally found in or produced by living bodies, and the healing properties of air, light, water, heat, and electricity. Provides for care of bodily functions, processes, or traumas, and treats nervous or muscular tensions, abnormalities of tissues, organs, muscles, joints, bones, and skin, pressure on nerves, blood vessels, and lymphatics, and assists patient in making adjustments of a mental and emotional nature. Naturopathy excludes the use of major surgery, X-ray, and radium for therapeutic purposes and the use of drugs with the exception of those substances which are assimilable, contain elements or compounds which are components of bodily tissues and are useable by body processes for maintenance of life.

Webster's Seventh New Collegiate Dictionary (G. & C. Merriam Company, 1965), on page 563, defines naturopathy as:

a system of treatment of disease emphasizing assistance to nature and including the use of natural medicinal substances and physical means (as manipulation and electrical treatment).

In his book "Basic Naturopathy" (1948, American Naturopathic Association, Inc.), Harry Riley Spittler, N.D., M.D., Ph.D., uses this definition:

Naturopathy is a complete system of practice, making use of nature's agencies, forces, and processes, and products for therapeutic purposes, exclusive of major surgery.

The definition adopted by N.A.N.P. is this:

Naturopathy (naturopathic medicine)—A system of treatment of human disease which emphasizes assisting nature. It embraces minor surgery and the use of nature's agents, forces, processes, and products, and introduces them to the human body by any means that will produce health-yielding results.

B. THE SCIENTIFIC BASIS OF NATUROPATHY

1. *Historical development*

One aspect of Naturopathy dates to the pre-Christian Egyptians—to their use of massage and manipulation of the body, its muscles, its tissues: the beginning of mechanotherapy. The Old Testament refers to subsequent Israelite rules governing diet and hygiene. The steam and vapor baths (early hydrotherapy) of middle Europe in the Middle Ages still obtain as does the use of cold and hot baths perfected by early Romans and Athenians.

The herbal, botanical side of naturopathy dates most clearly to the Chinese of 5,000 years ago, the discoverers of therapeutic value in ginseng, cascara, and other roots, flowers, and botanical substances.

Naturopathic education dates to the Athenian teachings of Esculapius during the 13th century B.C. Of the 300 "healing centers" in Greece which followed, 200-300 years B.C., one (at Kos) nurtured Hippocrates, father of modern medicine.

In 1050 A.D. the first "university of hygiene" was founded at Salerno, Italy; the initial book of health rules it produced went through 240 editions.

As the 12th century opened, universities were founded in Bologna, Montpellier, and Oxford. Paracelsus began experiments with the body's dependency upon sulphur, mercury, and salt, and with the concept of internal medication . . . giving birth to the theory of iatro-chemistry, the forerunner of contemporary pharmacology.

It could be held that naturopathy as a formal profession and discipline was recognized and legalized when the "Herbalist Charter" of King Henry VIII was enacted by England's Parliament. That document read in part:

Be it ordained, established, and enacted, by authority of this present Parliament, That all Time from henceforth it shall be lawful to every Person being the King's subject, having Knowledge and Experience of the Nature of Herbs, Roots, and Waters or of the Operation of the same, by Speculation or Practice, within any part of the Realm of England, or within any other of the King's Dominions, to practice, use, and minister in and to any outward Sore, Uncome Wound, Aspotemations, outward Swelling or Disease, any Herb or Herbs, Ointments, Bath, Pultess, and Emplaisters, according to their cunning, Experience, and Knowledge in any of the Diseases, Sores, and Maladies beforesaid, and all other like to the same, or Drinks for the Stone, Strangury, or Agues, without suit, vexation, trouble, penalty, or loss of their goods. . . .

Hydrotherapy, as an adjunct of natural healing, gained initial European prominence through the movement begun by Priessnitz at his institute in Grafenberg, Silesia in 1829. At first, lay patients, and later physicians, sought his teaching and help with such practical procedures as plunge, hot and cold packs, sitz baths, and compresses.

But hydrotherapy is only one of the many therapeutic techniques employed by naturopathy. Rickli delved into sunlight and air cures following Priessnitz' lead, beginning in 1848. Berg began research into vegetarian diet; Finsen, into ultra-violet treatment; Coue, into psychology; Schroch into warm moisture, dry diet, and fasting . . . all precursor scientists to the formal regimen of today's naturopathy.

The groundwork for naturopathy per se was laid by Hippocrates, when he wrote in a treatise on "Epidemic Diseases"—"Nature is the healer of all disease. Let foods be your Medicine and your Medicine your Foods."

The 19th century . . . from 1850 to 1900 particularly . . . fleshed-out Hippocrates' basic thesis. Man after man added to the body of knowledge concerning natural healing: Christian was the food scientist; Buckley was the first American physician to recognize the value of diet in treating cancer patients; Wilstatter, a German chemist, was first to study the healing properties of chlorophyll in treating anemia.

The 20th century practitioner who tied all the foregoing body of knowledge together, into the formal concepts of contemporary naturopathy, was Benedict Lust, born and educated in Germany, who introduced naturopathic healing to the United States in 1892, with the founding of his Yungborn Health Institution in New Jersey. . . . at the same time that Dr. Still propounded the philosophy of osteopathy and Dr. Palmer inaugurated the practice of chiropractic.

Naturopathy's pioneers, in addition to Lust, included Kellog, founder of the Battle Creek Sanitarium, and Hannamann, founder of homeopathy.

2. Scientific theories and principles

Naturopathy (naturopathic medicine) is the technique of treatment of human disease which emphasizes assisting nature. It can embrace minor surgery and the use of nature's agencies, forces, processes, and products, introducing them to the human body by any means that will produce health-yielding results.

Naturopathy is based upon the tendency of the body to maintain a balance and to heal itself. The purpose of naturopathic medicine is to further this process by using natural remedies . . . as distinct from "orthodox" medicine (allopathy and osteopathy), which seeks to combat disease by using remedies which are chosen to destroy the causative agent or which produce effects different from those produced by the disease treated (from the definition of "allopathy"—Webster's Seventh New College Dictionary; 1965; p. 24).

Naturopathy places priority upon these conditions as the bases for ill health: (1) lowered vitality; (2) abnormal composition of blood and lymph; (3) maladjustment of muscles, ligaments, bones, and neurotropic disturbances; (4) accumulation of waste matter and poison in the system; (5) germs, bacteria, and parasites which invade the body and flourish because of toxic states which may provide optimum conditions for their flourishing; (6) consideration of hereditary influences, and (7) psychological disturbances.

In applying naturopathic principles to healing, the practitioner may administer one or more of specified physiological, mechanical, nutritional, manual, phyto-therapeutic, or animal devices or substances. The practitioner's end aim is to remove obstacles to the body's normal functioning, applying natural forces to restore its recuperative facilities. Only those preparations and doses which act in harmony with the body economy are utilized, to alter perverse functions, cleanse body of its catabolic wastes, and promote its anabolic processes.

3. Supportive studies and research

Bibliographies containing reference works used in teaching undergraduate practitioners-to-be, and utilized, postgraduate, by practicing naturopathic physicians, are appended hereto, from the Library of Congress and from the National Library of Medicine in Bethesda, Maryland.

In sum, the texts on these appended bibliographies comprise the primary body of formal knowledge which governs the practice of naturopathy—the results of research emanating from or pertinent to this profession, and case studies which confirm the validity of the naturopathic mode of practice.

C. THE PRACTICE OF NATUROPATHY

1. Role of diagnosis

Diagnosis (as defined by Gould and as accepted by naturopathy) is the determination of the nature of a disease by—

Anatomical diagnosis: diagnosis based upon the recognition of definite anatomical alterations lying back of the phenomena ;

Post-mortem diagnosis: diagnosis made after death, by autopsy ;

Clinical diagnosis: diagnosis made from the symptoms alone ;

Differential diagnosis: distinguishing between two diseases of similar character by comparing their symptoms ;

Exclusion diagnosis: recognition of a disease by excluding all other known conditions ;

Pathological diagnosis: diagnosis of the structural lesions present in a disease ;

Physical diagnosis: determination of disease by inspection, palpation, percussion, or auscultation and observation ;

Topographical diagnosis: that based upon the seat of a lesion.

Diagnosis is, necessarily, each physician's prelude to prescription and/or treatment, as it is with all naturopathic physicians, albeit that diagnosis from verbal (orally-given) symptoms, is unacceptable. Naturopathy's forebearers may have set today's standards for diagnosis as a mandatory prelude to treatment. The chemist of George Washington's era, Carl Wilhelm Scheele, discarded from his apothecary shop the previously (and automatically) applied "iron from the nails of the coffins of criminals," etc., as "essential medications." Further symptoms alone are but one phase of diagnosis, for symptoms are to naturopathy, as Hippocrates wrote, "Partly symptoms of defense and partly symptoms of failure."

a. Interview

Techniques for patient interviews are generally consistent throughout naturopathic practice. Sample questionnaire forms for completion by physician and/or patient are appended. The personal interview is the naturopathic physician's first phase of diagnosis—observation, visual detection of obvious abnormalities of a physical or psychological character, aural detection of physiological (speech) or psychological abnormalities, etc.

During the interview, the naturopathic physician examines extensively for subjective symptoms which are revealed through conversation, and seeks maximum objective or subjective information following the diagnostic outline in 1. above.

b. Physical examination

Guidelines in the diagnostic outline of 1. above apply to physical examination of the patient as well as to aural-written notions.

Initial physical examinations, for new patients, are comprehensive, regardless of the nature of the patient's complaint—to establish history and ascertain with some exactitude the current status of the patient's body. Manual and visual examination of the body—its limbs, muscles, orifices, is routine.

The naturopath applies to his physical examinations of patients the principles in which he has been trained—osteology, Roentgenology, dermatology, syndes-mology, myology, neurology, topographical anatomy, ophthalmology, angiology, physiology, otalaryngology, clinical psychology, pediatrics, proctology, gynecology, obstetrics, etc.

Aside from data collected on a patient's questionnaire, the physical examination probes functions of the neuron and muscle fibers and their interdependence in myoneural action; physio-chemical phenomena associated in the process of osmosis, diffusion, and their bearing on such functions as pulmonary and cellular respiration, absorption, and secretion; the physiology of the heart, blood, and lymph; the excretory functions of the kidney (see following d.), skin, and lungs; the endocrine system and its role in the metabolic process; the function of the cerebrospinal and autonomous nervous systems; the physiology of the male and female generative systems.

c. Diagnostic aids

The naturopath's armamentarium includes every accepted diagnostic instrument: Sphygmomanometer; stethoscope, electro-cardiograph; endo-cardiograph; thermometer; speculums; proctoscopes; sigmoidoscopes; instruments for testing

reflexes, aural receptivity, and for testing pressure of the eyeball; scales; X-ray fluoroscopes—the gamut of modern medicine's diagnostic equipment. (Note: naturopathic physicians utilize X-ray for diagnostic purposes, *not for therapy*.)

d. Laboratory tests

The naturopathic physician is schooled in inorganic chemistry, bio-chemistry, biology, zoology, histology, microscopic anatomy, splanchnology, embryology, bacteriology, pathology, toxicology, trophology, endocrinology, etc.

He is trained in laboratory diagnosis, conducting his own tests or utilizing state health department or private laboratories for studies and evaluation. (A sample report form utilized by Oregon's Public Health Laboratory in reporting test results to naturopaths is appended.) The naturopath applies physiological and pathological chemistry to his analyses: micro-biology and micro-bacteriology, serology, and bio-chemistry.

All of the bodies' tissues, fluids and excretions are subject to examination during the course of laboratory testing as part of naturopathic diagnosis: urine, sputum, feces, epidermal abnormalities, gastric fluids, etc.

Blood testing, aside from its role as part of any general physical examination, is also conducted by the naturopath for the specific purpose of detecting venereal disease or as a concomitant to pre-and post-natal care and the prophylaxis of or informational reporting on new-born infants. Serology is an essential part of naturopaths' geriatric and gerontological practice.

2. Treatment methods

Obviously, treatment will vary with the condition which necessitates it. Generally speaking, naturopathy utilizes nature's agencies, forces, processes, and products, which may be applied to the body by using physiotherapy, mechanotherapy, or hydrotherapy. Botanical agents and biological remedies may be prescribed, for external application or internal consumption, and nutritional counseling may figure in treatment.

Iontophoresis is employed frequently to ionize certain remedies in the treatment of disease when it is deemed inadvisable to prescribe internal medication.

Naturopathy's overriding dictate . . . when the practitioner's decision to apply prophylactic or physiological therapeutics is being formulated . . . is that nature is a sensitive agent possessing the faculty of making her own cures.

The techniques applicable to naturopathic treatment of disease and illness are the same techniques applicable to treatment by an allopath, with greater emphasis upon hydrotherapy, massage, manipulation, or electrotherapy in necessary instances, and with greater utilization of medications in their natural or botanical form than in their chemically-created or derived form.

To draw a simple comparison, naturopathic gynecology and obstetrics parallel allopathic gynecology and obstetrics. Naturopathy's osteopathic treatment embraces the identical principles of clinical visceral neurology and orthopedics (minor surgery) as those guiding the osteopath. Similarly, naturopathy's uses of Roentgenology and radiology are no more radical than those of allopathy.

Naturopathy does, in general, rely less heavily on radical alteration of bodily functions and chemistry than do other healing arts. Naturopathy's primary stresses include light therapy (helio, light, ultra-violet, infra-red, chrome, etc.); electrotherapy (galvanic, faradic, sinusoidal, diathermic, etc.); vigrotherapy (oscillations, concussions, vibration, spondylotherapy); remedial exercises (kinesiotherapy, medical gymnastics, body mechanics, active and passive exercise); manipulations (osseous and soft tissue, mobilization and immobilization techniques, spinal therapy, manipulative and official surgery); vasomotor control; mechanical therapy (utilizing supporters, prosthetics, belts, casts, pneumotherapy, zone therapy, orthopedic devices); cryotherapy; biochemic therapy (nutritional—correcting deficiencies and employing corrective or hygienic nutrition, phyotherapy—using naturopathic botanicals, herbal, and vegetable materials as listed in "Naturae Medicina"; the use of tissue minerals and cell salts—Schuessler, vitamins, endocrines, etc.; vaporthrapy; colon therapy—irrigating agents and other products for the treatment pathoses of this region; autotherapies; climatotherapy.

3. Patient records

Refer to appended, sample patient interview (narrative case history) questionnaires and laboratory reports. Each practitioner maintains his own form of on-going record for detailing a patient's medical history or progress.

D. CONTRIBUTIONS OF NATUROPATHY TO THE HEALTH FIELD

1. *New knowledge*

See the appended bibliography of works utilized as references by this profession. These lists include works which are the product of naturopathic case studies or research.

Naturopathy's contribution to the formal, published body of medical research is limited because almost all of its practitioners are individuals, without the benefit of teaching hospitals, numerous clinics, or other study centers in which pure research—endowed privately or by government—can be conducted. Naturopathy's research is confined primarily to monographs printed in its professional publications or delivered orally at its conventions and other educational meetings.

Many naturopathic physicians feel that their profession's principles are still untried by the larger body of allopathic medicine, hence various naturopathic principles which are centuries old could still be considered "new" to the contemporary practitioner who has yet to utilize them in the late 20th century.

2. *New techniques*

Essentially, the answer to D. 1. above applies to this question, save that naturopathic undergraduate and postgraduate teaching and seminar curricula embrace every new concept, technique, medication, and instrument which becomes known to the healing arts generally (and which is within legal limitations upon naturopathic practice).

3. *New approaches to health*

Here it can be held without contradiction that naturopathy has led the way in the fields of nutrition, dietetics, metabolic chemistry, and in some areas of hydro- and physiotherapy. For example, long established naturopathic principles were given national esteem 25 years ago through the "Sister Kenny treatment" for poliomyelitis. Naturopathy's manipulative techniques have been substantially emulated by chiropractic. Naturopaths and their 19th-century forebears were the first to recognize validity in the hypnosis theses of Paracelsus, Cagliostro, von Helmont, Mesmer, and Braid. Naturopaths, in Freud's professional infancy, were already attuned to the value of psychotherapy.

Less dramatic than citing the naturopathic origins of new "truths" in 20th-century healing, but nonetheless illustrative of naturopathy's ever-modern approach to health, is a recitation of some of the current curricula at its National College of Naturopathic Medicine: applied psychology, suggestotherapy, auto-suggestion, therapeutic hypnosis, occupational therapeutics, psychosomatic therapy—are examples of naturopathy's academic currency.

III. *Practitioner*

A. TOTAL MANPOWER

1. *National*a. *Age*

The average age of today's naturopathic physician is 51.

b. *Sex*

Presently, about 90% of America's naturopathic physicians are male; 10% female.

c. *Active and inactive*

The precise number of inactive practitioners is not known. It is estimated that there are between 500–700 active and inactive naturopaths in those states with specific licensing or regulatory statutes or procedures, and an additional 3000–4000 active and inactive practitioners in states where naturopathic practice is conducted under common law.

2. *States, per 100,000 population*

There are approximately 2.2–2.5 naturopathic physicians per 100,000 people in the United States today.

B. ASSOCIATION MEMBERS

1. *National*a. *Age*

The same median age of 51 years applies to members as well as non-members.

b. *Sex*

The same (90% male, 10% female) breakdown applies to members as to non-members.

c. *Active and inactive*

Active (practicing) members, approximately, 95 percent.

Inactive (non-practicing) members, 5 percent.

2. *States, per 100,000 population*

In the seven states where there are N.A.N.P.-affiliated chapters or associations, the ratio of member practitioners to each 100,000 of that state's population would be approximately: Oregon, 1.1; Washington, .9; Idaho, 3.7; Kansas, .7; New York, .04; Connecticut, .96; California, .1.

In states containing practitioners not associated with a local association, but nonetheless active N.A.N.P. members (32 in Nevada, Colorado, and Arizona), the median ratio of practitioner-per-100,000 population within the entire tri-state area would be .9.

C. USUAL LOCATION OF PRACTICE OR ACTIVITY

1. *General or short-stay hospitals*

N.A.N.P. has no knowledge of any specifically naturopathic hospital in the United States, although there are hospitals operated by religious orders, private trusts, non-profit organizations or corporations, or by other healing arts professions to which naturopathic patients (and naturopathic physicians) are admitted on par with other patients and practitioners.

Where naturopaths are admitted to such hospitals, and where naturopaths utilize minor surgery, such surgery is conducted in accordance with legal limitations upon naturopathic practitioners, and/or in accordance with the particular hospital's staff rules.

2. *Specialty or long-stay hospitals*

As stated above, N.A.N.P. knows of none.

3. *Other inpatient institutions*

A substantial number of such facilities—primarily rest and convalescent homes—admit patients under naturopathic care on par with all other patients.

4. *Outpatient facilities*

Ambulance services, clinics (school and private), patients' homes, practitioners' offices, rehabilitation centers—are available to and utilized by naturopathic physicians.

5. *Agencies and organizations*

As contributing members of the national health-care fraternity, naturopathic physicians confer with and lend counsel to such entities (as an example) as Oregon's Advisory Board to its State Board of Health and the Oregon Inter-professional Health Council previously described. Naturopaths can and do minister to welfare recipients, to recipients of industrial accident insurance benefits, etc. Naturopaths are available as practitioners and clinicians to any entity of local, state, or federal government which wishes to employ their talents.

In such facilities as the National College of Naturopathic Medicine, outpatients are treated by practitioners and their students on a clinical basis.

D. TYPES OF PRACTITIONERS : GENERAL AND SPECIALITIES

1. Scope of practice

Naturopaths work within specific statutory limits, which usually prohibit major surgery and the administration of narcotics. Such statutes are not only acceptable to naturopathy but, in some instances, have been engendered by naturopathy, which believes—as one case in point—that major surgery is a highly limited, highly specialized field of medical service which, when necessary, should be performed by those allopathic practitioners who devote most of their time to that art.

Because naturopathy is by root a natural mode of healing, the restrictions against administration of narcotics are welcomed and encouraged by naturopaths.

Naturopaths have no aversion to referring. Naturopathy's educational curricula is inclusive of most elements of allopathy, but naturopathic practitioners utilize this training *diagnostically* in large part, referring extensively to allopaths or more specialized practitioners (podiatrists, optometrists, dentists, chiropractors, etc.) where initial diagnosis dictates or where subsequent therapy is unfruitful or where symptoms remain unabated under purely naturopathic therapy.

As an example of statutory limitations upon this profession, the salient Oregon law governing naturopathy is appended.

Roughly 90% of today's naturopathic physicians are in general practice; 10% specialize—in pediatrics, obstetrics, gynecology, proctology, dermatology, chiropractic, etc.

2. Size of practice

The average naturopathic practitioner serves a patient population of 2000 yearly.

3. Limitations of practice

D. 1., above, touches this subject, as do the appended Oregon licensing statutes (as sample statutory language). "Limit" and "scope" of practice are in a sense synonymous.

Naturopaths in the main serve geriatric patients, by choice, not fiat. Naturopathic rights extend from pre-natal care (and subsequent obstetrics), through the detection and reporting of contagion, to signing birth and death certificates. Naturopaths are prohibited from performing major surgery, but can perform minor surgery.

Intermingling this answer with that to D.1. above, naturopaths can and do diagnose, apply naturopathic therapy to, and thereby treat, acute infectious disease and abnormalities of the digestive system, the respiratory system, the cardiovascular system, the urinary system, the hemopoetic system, the nervous system, and the endocrine system.

The only weapons they cannot bring to bear upon conditions within this systemic list are major surgery, the prescription of narcotics, and the administration of radiation therapeutically.

Additionally, because of hospital rules in most instances not law, naturopaths are limited in (or restricted from) practicing in general hospitals. Therefore, when there is need for specialized care within the confines of a hospital, the naturopath—of procedural necessity—most often refers to an appropriate practitioner admissible to such hospitals.

4. Practice conducted on authorization or under supervision of another health care practitioner

Naturopaths do not practice as "technicians" for allopaths or any other practitioners. In general, they practice independently of supervision—neither their diagnoses nor their therapy nor prescribed medications are subject to review (by law or protocol) by any other practitioners. Naturopaths refer extensively. This has been dealt with in prior answers, and to the extent that the specialist and the naturopath who referred a patient to him may confer on continuing diagnoses or treatment, there is consultation and cooperation, but not implied or actual supervision by one doctor over another.

5. What percent of service is given in independent practice?

100% of most naturopathic practice is devoted to individual patients, on a non-clinical basis. If the question refers to modes of payment for individuals' treatment, it is estimated that 80% of all naturopathic patients are personally responsible for their physicians' billings; 20% are "Medicaid", welfare, industrial accident, or private-public insurance carrier benefit recipients.

E. RELATIONSHIPS TO OTHER HEALTH CARE PRACTITIONERS

1. Referral

a. *To allopaths, chiropractors, other naturopaths, optometrists, podiatrists, osteopaths, dentists, pharmacists, nurses*

(1) *Who refers.*—The naturopathic physician.

(2) *Why.*—When the naturopathic physician feels that specialized attention is in the best interest of the patient.

The appended N.A.N.P. Code of Ethics touches upon referral in several ways. Articles I, Section 7 states that the "naturopathic physician may decline to attend a patient when he deems the treatment required is beyond the scope of his license"; Article I, Section 8 states that "The naturopathic physician shall act upon the desire of the patient for consultation or if he deems his art, skill, or experience inadequate, he shall advise consultation"; Article III, Section 2 states that "The attending physician shall give the case history and laboratory and clinical findings to the consulting physician".

b. *From other naturopathic physicians, chiropractors, optometrists, podiatrists, osteopaths, allopaths, nurses, dentists, and pharmacists*

(1) *To whom referred.*—The naturopathic physician.

(2) *Why.*—Re-referral of an originally-naturopathic patient, when the specialist's course of treatment (or major surgery) is concluded, or when the natural healing techniques of naturopathy are indicated as most potentially beneficial, or, lacking a specific, when the best interest of the patient would be so served (or when the patient himself requests such consultation or referral).

2. Consultation

a. *Given by any of the practitioners named in 1. a. and b. above*

(1) *Who requests.*—The patient, his attending naturopath, or a member of another healing arts profession who is either a family retainer or who has been called upon by the patient or the attending naturopath.

(2) *Why.*—As recited in 1. a. and b. above, primarily, because of the best interest of the patient.

b. *Requested by the patient, the attending naturopathic physician, or a member of another health care profession*

(1) *Who provides.*—Any of the practitioners named in 1. a. and b. above.

(2) *Why.*—More extensive diagnosis is indicated or a specialist's particular attention is desired.

F. MAJOR PROBLEMS PRESENTED BY PATIENTS TO PRACTITIONER

1. All patients

Patients under 40 years of age account for the highest percentage of acute illnesses and infections, trauma, and musculo-skeletal problems. Problems affecting patients over 40 but under 65 are more or less chronic in character.

2. Patients 65 and over

More geriatric/gerontological in nature, the problems of the elderly are progressively chronic as age advances, and are primarily cardio-vascular or respiratory and are generally degenerative.

G. ACTIVITIES OTHER THAN DIRECT PATIENT CARE

Teaching is of necessity confined to those practitioners headquartered near the National College of Naturopathic Medicine—in the Pacific Northwest; 30 licensed naturopaths currently serve as full- or part-time faculty members at the College,

with the ranks of Assistant or Associate Professor, X-Ray Technician, and Clinical Laboratory Technologist.

Six naturopaths hold full Professorships at the College; college administration is handled by a staff including five naturopaths, and eight naturopaths comprise the College's rank of officers and trustees.

Naturopaths serve on state boards of examiners and other licensing or regulatory bodies administering their own or allied professions.

Naturopaths report contagious and infectious diseases to their respective departments of health; issue birth and death certificates; serve on formal or informal interprofessional health councils; support food chemistry and nutritional research.

H. RELATIONSHIPS WITH THIRD-PARTY PAYERS

1. *Federal programs*

Naturopathy's involvement is not consistent state-to-state, depending upon the number of practitioners and status of the profession in a given state, and depending upon the state's degree of implementation of federal programs requiring matching state participation. In Oregon, for instance, naturopaths are included in the coverage provisions of Title XIX—"Medicaid" (Chapter 502, Oregon laws, 1967; ORS 414.025, Section 3. In Bremerton, Washington, another case in point, naturopaths' services to U. S. Navy personnel are paid for federally.

2. *Blue Cross*

Payments to naturopaths from Blue Cross-affiliated societies or corporations have been limited to emergency diagnostic procedures and laboratory work.

3. *Blue Shield*

The above answer to H. 2. applies here.

4. *Commercial insurance companies*

Many private carriers honor naturopathic billings, in whole or in specified (within varying policy limits) part, among them Standard Insurance Co., Mutual of Omaha, Continental Casualty Co., Bankers Life & Casualty, Monarch Life, and New York Life—all of which pay for naturopathic services *in full*.

5. *Consumer-sponsored organizations*

Some trade union-sponsored health care plans honor naturopathic billings. The profession, to our knowledge, does not deal through any other consumer-sponsored third-party payers at this time.

IV. *Education*

A. ACCREDITATION PROCEDURE FOR SCHOOLS OF TRAINING PROGRAMS

1. *Accreditation body*

As described in detail in the appended "Directives to Council on Education and Syllabus of Minimum Curriculum for the Guidance of Accredited Naturopathic Colleges", three bodies adopted the current accreditation standards for naturopathic institutions of higher learning—the profession's Council on Education, the Council on State Boards of Naturopathic Examiners, and the House of Delegates of the American (now National) Association of Naturopathic Physicians. Their action was taken in July, 1953.

Membership of the Council on Education comprises representatives of currently or provisionally accredited schools and an equivalent representation from the general body of practicing naturopaths, the latter being named by the Board of Trustees of N.A.N.P. The Council on State Boards of Naturopathic Examiners comprises representatives from each state maintaining such a licensing and examining body. The House of Delegates of the N.A.N.P. is the national Association's primary policy-making body of delegate members from states in which it has individual members or affiliated local associations.

Applications for accreditation are reviewed by the three above-named groups, either in concert or singly (i.e., the House of Delegates normally convenes only during annual N.A.N.P. conventions).

(Note: As has been recited earlier, the National College of Naturopathic Medicine is the single active teaching facility in the United States at present, although N.A.N.P. is informed that the former Sierra States University, 1413 7th Street, Santa Monica, California, may be in the process of reorganization and may seek re-accreditation. In Canada (we note this because of the cross-border character of naturopathy, whose practitioners' credentials are virtually identical throughout North America), the Institut de Naturopathie du Quebec, 150 Quest Laurier, Montreal, Quebec, Canada—Raymond Barbeau, Director, has applied for accreditation and its courses have been approved for the purpose of transferring credits to United States naturopathic facilities.)

2. *Process of accreditation*

Application must be made concurrently to the three approval bodies described above in A. 1., and approval must be forthcoming from all three bodies. For further detail, see the appended Syllabus, pp. 1-4.

3. *Accreditation requirements*

See the attached Syllabus.

a. *Curriculum*

See attached Syllabus and appended course catalog for the National College of Naturopathic Medicine.

(1) *Courses*

(a) *Subject matter*

See the attached Syllabus and course catalog.

(b) *Hours per course*

See the attached Syllabus and course catalog.

(c) *Texts*

See the attached course catalog. Supplementary textual matter—documents not required to be in student possession, are on library loan. See the appended bibliographies of naturopathic reference works for sample titles.

(2) *Course hours*

(a) *Academic: number and percent*

3618 hours required; 77.33% of total required course hours.

(b) *Clinical: number and percent*

1088 hours required; 22.67% of total required course hours.

Outpatient training.—No hospital facilities are available for outpatient training.

Hospital training.—See above answer.

For other clinical training, see the answer to IV. A.3.a. (2). (b), above.

(c) *Internship or field training*

Students receive practical experience in the National College of Naturopathic Medicine's clinic, in the College building, at 1327 North 45th Street, Seattle, Washington 98103, and through externship in the offices of various faculty member naturopaths.

Externships and clinical assignments are based upon a student's need and prior experience. Thus, an experienced chiropractor entering the College as a senior-year student would not be placed in the office of a specialist in osteology, nor a former obstetrical nurse or midwife placed with an obstetrics specialist. All students, however, are required to spend 80 hours in obstetrical internship and to aid in two or more deliveries.

(3) *Grading systems*

See attached course catalog.

(a) *(a. was omitted on questionnaire)*

(b) *Entrance qualifications*

See attached course catalog and Syllabus.

c. *Faculty*

(1) *Qualifications*

See attached course catalog and Syllabus. The N.C.N.M. faculty is largely

volunteer; practitioners from British Columbia, Washington, and Oregon. Many have Bachelors degrees; all have N.D. degrees and are licensed to practice. The College President holds B.S., M.A., and Th. D. degrees; the clinical nurse holds B.S. and R.N. degrees. (Note: The faculty of the Institut de Naturopathie du Quebec is equally qualified; see appended photo-copy of page 4 of the Institut's catalog.)

(2) *Number students per faculty member*

A condition of accreditation is that the College shall maintain at least one faculty member per 25 students. Because of the diverse number of academic subjects in the College's curricula, and the over-all faculty size (30-plus), there are considerably less than 25 students working with one teacher at any given time.

d. *Physical plant*

The N.C.N.M. building is at 1327 North 45th Street, Seattle, Washington, where most classes and clinical training in naturopathic medicine are conducted. The building was purchased in May, 1964, for \$45,000, has since been remodeled, and is now valued in excess of \$50,000. The building contains a fully-equipped clinic, administrative offices, and two classrooms on its lower (ground) floor, and one classroom and three living quarters on its second floor. Current planning calls for transforming the living-quarter space to additional classrooms, a laboratory, and a dissecting room.

(1) *Laboratories*

The College contains one laboratory, operated in conjunction with its clinic. Remodeled and refurbished in the spring of 1968, this laboratory is equipped and utilized for conducting clinical testing, but is too small for extensive research.

(2) *Libraries*

The N.C.N.M. maintains a 5000-volume library, most of its works dealing with natural drugs—older books whose content remains unchanged by any but radical research innovation. Because of the relatively static character of naturopathic publishing, the library remains valid and is more adequate than the sheer number of volumes would imply.

(3) *Clinical facilities*

The student clinic at the Seattle College building has adequate facilities and modalities for all of naturopathic practice except obstetrics. Space is limited, however, to four students working there at any given time; students therefore rotate between days in the clinic and externships in various professional offices within the greater Seattle area, on an assigned, pre-arranged basis, according to student needs and preferences.

e. *Postgraduate education program:*

Formal postgraduate work offered by the National College of Naturopathic Medicine has been limited to instruction necessary for graduates of predecessor colleges (which required only 4000 hours of classroom teaching) to reach the 4400- to 4800-hour level now required for practice in many states. N.C.N.M. has not initiated course work toward the Ph.D. degree, nor residencies toward specialization, because of inadequate research facilities. The College is working presently on a program to equip itself to offer a Ph.D. in nutrition.

Informal postgraduate educational work, to keep naturopathic practitioners abreast of developments in their own field, as well as in general medicine, includes:

(1) *International and national association conventions:*

At least one 8-hour day during each such convention is devoted to discussion and consideration of recent developments in naturopathic science.

(2) *Joint Northwest regional naturopathic conventions:*

Once a year, practitioners from Oregon, Washington, Idaho, British Columbia, Alberta, Saskatchewan, and other northwest areas convene in one of these states or provinces to share new knowledge. Speakers are also invited, from other professions (see appended 1968 N.N.P.C. program) to conduct seminars; usually 20 hours of each such meeting are devoted to professional postgraduate education.

(3) *State meetings*

Where there is an N.A.N.P.-affiliated state association, or where registries of practitioners are maintained, these formal or informal groups of naturopaths hold meetings at intervals which vary from state to state (but no less than once annually) during which at least one half-day is devoted to educational programs.

(4) *Seminars*

In the Pacific Northwest, the College in Seattle and area-wide local associations sponsor a monthly series of week-end professional education seminars. These seminars usually occupy all of Saturday afternoon and evening, and Sunday morning. They vary in content from simple demonstrations in the use or operation of new modalities (such as newer types of electrocardiographs, sphygmomanometers, electro-therapy apparatus, etc.) to technical training in such subjects as proctology, otolaryngology, obstetrics, etc.

Students of the National College of Naturopathic Medicine are admitted to such seminars, but receive no course credits for attendance. The N.C.N.M. does grant one-quarter-hour of post graduate course credit for attendance to those naturopaths who are currently also engaged in extensive and pre-arranged reading courses on the subject at hand.

Note: The current tendency among naturopathic licensing and regulatory boards is to seek legislation to make a required number of annual postgraduate study hours mandatory by law as a prerequisite to re-licensing. N.A.N.P. is encouraging not only expanded postgraduate education but the concept of making it mandatory for all practitioners. (See sample proposed Oregon law.)

B. TRENDS IN EDUCATION

Perhaps the early history of the now-dormant Sierra States University mentioned in IV.A.1. above portends the practical and probable direction of future naturopathic education.

Sierra States, chartered in California in 1921, maintained colleges in naturopathy, chiropractic, physical therapy, psychology, and allied subjects. During its existence in San Francisco, from 1921-1950 (it moved to Los Angeles in 1950, then to its present Santa Monica location), Sierra States graduated probably 1000 practitioners in the various healing arts for which it was authorized to issue degrees. During its 1950-1961 period in Los Angeles, Sierra States graduated 200 naturopath/chiropractors.

The National College of Naturopathic Medicine is suffering from a dearth of students—as are many private liberal arts colleges and universities, and most private and public colleges and universities graduating allopathic physicians, optometrists, dentists, etc. Potential student interest in the healing arts is at the same low ebb among all health care professions. Student bodies are very often not commensurate with the size of the teaching facilities maintained to educate them. Recruiting must become more aggressive (see D. to follow).

Our point is that it may now be apropos for increased mergers of various colleges and universities currently devoted to single arms of the healing arts, into more workable, economically feasible teaching entities.

To that end, naturopathy is conducting inquiries among private liberal arts, business, theological, and health care-dedicated Pacific Northwest universities and colleges to determine their interest in merger with N.C.N.M. It would be premature to reveal the exact nature of these negotiations or the precise identities of the educational institutions involved.

It is hoped that such a resultant institution—headquartered on one campus in either Oregon or Washington—could and would serve students primarily from throughout the western United States and Canada, but affording equal entree to students from the remainder of the U.S. and Canada.

N.C.N.M. foresees no drastic changes in its current curricula, except for the addition of postgraduate courses leading to higher degrees than the N.D. (a merged university as described above, parenthetically, could take a student through his requisite pre-naturopathic undergraduate years' to a B.S. or B.A. if he desired, then through an N.D. degree, and subsequently through an M.S. or Ph.D. degree—on one campus).

Obviously it follows that, if postgraduate-level education is achievable on the basis described above, massively increased naturopathic research will follow, utilizing the clinical and laboratory facilities which must attend postgraduate teaching and which do not now exist in adequate proportion at N.C.N.M.

Merger or not, N.C.N.M. plans—as described in IV.A.3.d. above—to increase the physical size of its laboratory-clinic space in the near future, and plans to strengthen its postgraduate curricula. The moves in several states to make postgraduate education mandatory (as described in IV.A.3.e.(4). above) can work to the benefit of N.C.N.M., which is the most logical entity to devise continuous postgraduate educational courses, provide the faculty to teach them, and to sponsor and conduct such classes wherever and whenever they are taught throughout the United States, thereby also increasing the breadth of its undergraduate curriculum, its faculty's prowess, its income, and its general financial and professional stability.

Specific areas of curriculum change are difficult to forecast. The governing bodies of N.C.N.M. foresee increased stress upon the academics of diagnosis and treatment which are concerned with geriatrics and gerontology, and, conversely, with pediatrics. Diseases affecting both the elderly and the very young are receiving primary research attention from America's healing arts today. Application of that research, to both prolong life and nurture new life, must occupy naturopathy's concern to an extent commensurate with that of allied health care professions.

Increased curricular stress upon chemistry and its multi-phases is also called for as medications grow more sophisticated (and potentially dangerous in some cases); increased attention to radiography and the effects or countering of radiation will likewise demand more curricular attention.

Naturopathy's most basic educational theses will become increasingly focused upon practical in-office, in-clinic, or in-home experience. Medicine's trend today, which naturopathy supports, is reversion to the "general practitioner" concept of healing—putting theoretical teaching in a less commanding perspective, in favor of "bedside psychology" and its person-to-person emphasis.

C. ENROLLMENT BY CLASSES SINCE 1960

Sierra States University, heretofore mentioned, and the Institut de Naturopathie du Quebec, have either not been appreciably operative since 1960—in the former instance, or the N.A.N.P. does not possess by-year enrollment statistics, in the latter case.

Here are data for the National College of Naturopathic Medicine:

Student capacity in (actual enrollment):

1960	-----	6	1965	-----	7
1961	-----	6	1966	-----	7
1962	-----	7	1967	-----	12
1963	-----	13	1968	-----	7
1964	-----	9			

Number of graduates in:

1960	-----	—	1965	-----	2
1961	-----	2	1966	-----	—
1962	-----	2	1967	-----	4
1963	-----	2	1968	-----	3
1964	-----	1			

D. RECRUITMENT TECHNIQUE OF SCHOOLS:

N.C.N.M. has—with obviously adverse effect upon its enrollment over the years—let naturopathy's inducements virtually speak for themselves, through the mouths of zealot practitioners, when and where a convenient time to proselyte has arisen.

This almost tacit course of action cannot continue, as all other health care educators have found.

Therefore N.A.N.P. is embarking now, with and for N.C.N.M.'s aid and benefit, upon a program of distributing literature describing this profession, its educational facilities, and its prospects economically and socially as a career, to high school students, through their vocational counselors, local employment services, and faculty members teaching high school science courses.

Naturopaths are beginning to take advantage of "Business-Education Days" and/or "Career Days", in which high school students visit business or professional offices or plants, in fields in which they have expressed even tentative interest, to obtain exposure to these professions and analyze their career potentials.

Catalogs (as the appended N.C.N.M. course catalog), and pamphlets (as the appended "Brief Respecting Naturopathy in the United States"), and other literature documenting median practitioner income, areas where practitioners are especially needed, etc., are in the planning stage now by N.A.N.P. and N.C.N.M.

Special student tours to N.C.N.M. are being planned also, for the Pacific Northwest area, under N.A.N.P. auspices. Outside this geographic area, individual practitioners will be given kits of informational materials for direct contact with vocational counselors or for classroom or in-office presentations to students.

It is hoped, naturally, that federal aid can be obtained in time on the same basis that the Congress has dispensed aid to other health-care professions for building, research, short- and long-term student loans, and other operational costs, to assist naturopathy in its new recruiting program.

V. Title XVIII (Medicare):

A. RECOMMENDATIONS TO THE CONGRESS FOR CHANGES IN THE SOCIAL SECURITY ACT TO BROADEN HEALTH COVERAGE FOR PEOPLE 65 OR OVER, AND PRIORITIES FOR SUCH CHANGES IN SERVICE:

It is manifestly and abundantly apparent in America today that allopathy cannot by itself serve all of the nation's ill.

The stated or implied aim of allopathy to seek licensing latitude for creation of "medical technicians" to assist its licensed practitioners and thereby enlarge the scope of their practice in numbers of patients to be served is commendable.

But there are a number of distinct, licensed, and historically-rooted disciplines, among them naturopathic medicine, whose practitioners cannot and should not be subverted to the role of "medical technician."

Their patient load is substantial, albeit in some cases the number of their active practitioners may be actually or seemingly on the decline (due to the decline in student enrollment mentioned before).

Therefore, naturopathy would urge the Congress to allow the terms and conditions of Title XVIII to embrace all licensed healing arts; each of which would treat patients and be indemnified for so doing, *only within the scope of its licensed ability to do so*; i.e., there is no thought of encroachment upon the allopath's primary domain in naturopathy's attitudes or in this suggestion.

The priority for such inclusion is immediate; the practitioners—such as naturopaths—are *in* practice; they *are* treating patients; they will *continue* to do so, and far from atrophying, their self-educational and undergraduate educational programs are being revitalized to provide even more extensive service to the American public.

In sum, Title XVIII should be so amended as to allow complete "freedom of choice" by patients covered under the Act, of practitioner, location, type of treatment, etc. And such practitioners should be compensated on the same basis applicable to allopaths.

Naturopathy will not and does not advocate further philosophical changes in the Act; i.e., the N.A.N.P. does not advocate socialized medicine per se. It does advocate equally inclusive treatment of all health-care practitioners, however, in all present or future Congressionally-enacted programs for federally subsidized or supervised group or individual health care.

B. WHAT IS THE DEMAND FOR THE SERVICES OF NATUROPATHIC PRACTITIONERS BY PERSONS 65 OR OVER?:

N.A.N.P. estimates that approximately 9,400,000 patients are being served currently, per year, by America's roughly 4700 licensed and/or/otherwise regulated naturopathic practitioners. Of that number, we estimate that 25% of the patients of naturopathic practitioners in general (vs. specialized) practice are 65 or older. Therefore, if the per-practitioner, per-year, median patient load is 2000, then 25% of each naturopath's patients (500 per year) fall into the 65-or-older age bracket.

C. PROJECTION OF THE FUTURE NEEDS OF, AND DEMANDS FOR, THE SERVICES OF NATUROPATHIC PHYSICIANS BY PERSONS 65 OR OVER—IN 1975—IN 1980:

We are told that by 1975 roughly 50% of this nation's population will be 25 or younger. At the other end of the age spectrum, we forecast a significant yearly growth in the percentage of our population over 65. The healing, remedial, and

generally life-prolonging product of geriatric and gerontological research and practice is vastly extended individual and collective longevity.

In spite of this increasing annual extension of our population's longevity, the ills of the elderly seem to remain primarily the same . . . mainly chronic, mainly cardio-vascular or respiratory, and generally degenerative. Naturopathy forseees no appreciable change in the *type* of abnormal conditions it encounters in elderly patients, in spite of their longer lives. The toxicity of their excesses (alcohol, tobacco); the adverse changes in their ecology (air and water pollution) would indicate continuation of their afflictions at about the same level as today by the years 1975 or 1980. (Even the currently radical concepts of organic transplant, surgically, if eventually fully successful, can regenerate *only* the organ involved, and cannot effect therapy for the remainder of the patient's systems and organs.)

Therefore, naturopathy's needs for more teaching facilities, to produce more practitioners, to care for a growing number of persons who comprise this profession's primary patient source . . . the elderly, must be envisioned as one of constant increase. Specific numbers are not practical to recite here. Even arithmetical ratios between the growing number of persons over 65 or to become over 65 and the naturopathic population which is extant or which should exist to serve them would be misleading: because we do not feel that, *today*, there are even a tenth of the necessary minimum number of naturopaths in practice in the United States. To extend this current equation would be faulty and a misleading understatement of potential public need for naturopathy's services.

Mr. PRATT. Thank you, Mr. Chiarman. [Continues reading]

In other words, we feel that the Congress has been denied access to the contents of the brief which took us almost six months to compile. We stand on the statement as originally drafted as nothing materially new has transpired since then to change its content.

Mounting evidence now exists that the gap between the application of professional skill and the urgent need for such service is more real than was suspected and it is the opinion of many interested citizens that the inclusion of other types of licensed practitioners in the Supplementary Medical Insurance program of the Social Security Act would be of immediate benefit in bridging the gap.

According to the American Medical News for October 13, 1969, health manpower and health services are absolute top priorities in the health care field and Secretary Robert Finch of the Department of Health, Education and Welfare, is especially enthusiastic about using returning Vietnam medical corpsmen to augment the hard-pressed physician in reducing the serious shortage of doctors.

In a recent interview with reporters from the U.S. News & World Report of November 3, 1969, Dr. John A. D. Cooper, President, Association of American Medical Colleges, pointed out that President Nixon, in presenting a White House report on health-care needs, said there was a severe crisis in health-care delivery, and that part of this crisis was lack of an adequate number of physicians and other manpower in this field. President Nixon further stated that unless corrective measures are taken, we face a complete breakdown in the system in two or three years.

The National Association of Naturopathic Physicians feels that the inclusion of other types of licensed practitioners in the Social Security Act would help close the gap between the lack of skilled service and its application to the needs of the elderly citizen of the United States.

Since the minority groups in the health care field offer *alternative* service, rather than additional service, it is unlikely that the addition of these practitioners to the Social Security program would entail any additional cost to the administration of the program.

Your courtesy in considering our request is greatly appreciated.

This is signed by John W. Noble, N.D., president of the National Association of Naturopathic Physicians.

Mr. Chairman, would I have time to read a page and a half of my own statement.

The CHAIRMAN. Go right ahead.

Mr. PRATT. Which is similar to the one I prepared a week ago on behalf of another association from California.

Your witness, Charles Orlando Pratt, respectfully presents this statement on behalf of the National Association of Naturopathic Physicians, 1920 N. Kirkpatrick Street, Portland, Oregon 97217, which is devoted to the cause of strengthening and conserving public health through the philosophy, art, science, and practice of naturopathy.

The Association urges Congress to amend the Social Security Act so that the American citizens, using the care of doctors of naturopathy licensed in their states, shall be entitled to all the benefits of the program of supplementary medical insurance for the aged.

The Association believes Congress should make no law which abridges privileges or immunities of United States citizens in health care. The power of medical majority opinion could open the way for crushing verdicts that may stifle minority ideas in health care at the expense of the public welfare and the aged citizens.

The Association believes United States citizens and licensed doctors of naturopathy should not be denied by Congress equal protection of the laws by denying them the benefits of the Social Security Act.

The Association believes Congress should not deprive anyone the liberty to choose his kind of health care from, and by, a licensed doctor of naturopathy.

The Association believes the absence of a provision in the Social Security Act providing for payments for the services of Naturopathic Physicians, under the program of supplementary medical insurance benefits for the aged, may, in truth and in fact, constitute an unconstitutional, and an unlawful abridgement of the privileges and immunities of citizens of the United States. Such denial does deprive the citizen of his property right and liberty to choose and use the healing arts care which he believes is, or will be, most beneficial to him. Such denial does, indeed, deny the United States citizen the equal protection of the Federal health laws.

The Association believes freedom of choice in health care is an inalienable right, which is necessary to secure the blessings of liberty and to promote the general welfare in health matters.

Patients of Naturopathic Physicians, and the physicians, are tax-paying citizens. Their taxes are used to pay for health and medical care and facilities under the Social Security Act. The use of this health care and these facilities is denied patients of Naturopathic Physicians; and, thereby, their rights and privileges are denied.

Medical and allied professions, for whose services Congress has provided payment of supplementary medical insurance benefits for the aged, may not be able to do the whole job of protecting the health and welfare of the citizens, because millions of Americans do not use or want drugs unless required by law.

And I mean required in connection with contagious diseases so as not to harm someone else.

Millions of Americans are justifiably afraid to use the powerful drugs, antibiotics and medicines on the market today, because of the repeated public revelation by government, press, radio and television, that such products have dangerous, serious and sometimes deadly side effects. These citizens, therefore, want to have available to them the professional advice and care of licensed doctors engaged in the healing arts professions, who do not recommend or use such products

I might add here that these doctors are more or less sort of the practical side of Christian Scientists. They don't believe too much in using drugs. They would like to use a lot of natural foods and wholesome foods, and small as possible doses of any kind of drug on the market.

We all know that some 400 drugs are being recalled right now because of dangerous side effects of these drugs which have been on the market.

Congress should do justice to all citizens by providing for the use of Federal tax revenues, under the provisions of the Social Security Act, to pay for the health services of patients of doctors of naturopathy duly licensed under state law.

And I would like to point out that we are not asking for any help for any doctors not properly licensed under the State law.

Patients of Naturopathic Physicians should have the same and equal right to have federal assistance in paying their health bills as do the patients of the other healing arts professions. These citizens should not be deprived of federal help.

American citizens should not be compelled, directly or indirectly, to be cared for, or treated, according to a majority opinion on health care.

America has grown strong by protecting minority rights against the overwhelming power and influence of the majority. This principle applies as much today in the need to protect minority rights of the patients of the Naturopathic Physician as it applies to protect minority rights in religious or civil liberties.

Congress should do not less than to protect the minority privileges and immunities of all Americans who need and want health care from Naturopathic Physicians.

Congress should do not less than to guarantee to all patients of doctors of naturopathy the equal protection of the Social Security Act.

I mean doctors properly licensed by their States.

The best interests of the government and of the people will be served thereby.

Respectfully submitted, . . .

Mr. Chairman, this statement is respectfully submitted by the National Association of Naturopathic Physicians, by its Washington general counsel.

Thank you very much for your patience and your courtesy.

The CHAIRMAN. We thank you, Mr. Pratt, for coming to the committee.

Are there any questions?

If not, we thank you very much.

Mr. PRATT. Thank you, sir.

The CHAIRMAN. That completes the calendar for today.

Without objection, the committee will adjourn until Wednesday morning, November 12, at 10 o'clock.

(Whereupon, at 1:10 p.m., the committee adjourned, to reconvene at 10 a.m., on Wednesday, November 12, 1969.)

SOCIAL SECURITY AND WELFARE PROPOSALS

WEDNESDAY, NOVEMBER 12, 1969

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Al Ullman, presiding.

Mr. ULLMAN. The committee will come to order.

I see in the committee room our distinguished colleague from New Jersey, Mr. Patten.

We would be very happy to hear you at this time, Mr. Patten.

STATEMENT OF HON. EDWARD J. PATTEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PATTEN. Thank you, Mr. Chairman, members of the committee.

Mr. ULLMAN. We are very happy to hear you at this time and pleased that you saw fit to bring your views before this committee.

You may proceed, sir.

Mr. PATTEN. Mr. Chairman and members of the committee, thank you for the opportunity to appear before you today.

SUMMARY

I. Provide increased cash benefits where both husband and wife work. Present law does not provide second working spouse with proportionate benefits relative to contributions paid into the social security fund.

II. Under present law, a non-working spouse can receive higher benefits than a spouse who works and contributes to the fund.

III. Increase "wage retirement test" to \$2,400 so retirees can meet the high cost-of-living expenses in today's society.

IV. Liberalize conditions under which disability insurance benefits are paid to blind people.

WORKING SPOUSES

For some time I have been concerned about the way married working women are treated under the social security program. They pay the same social security taxes paid by working man, but in many cases get little or nothing in return. Each time the Social Security Administration revises the estimates of the long-range cost of the social security program, the revised estimates show a reduction in the cost of the program, in significant measure due to higher labor-force participation rates for women. In his memorandum on the most recent revision of the long-range cost estimates, the Chief Actuary of the Social Security Administration, Robert J. Myers, indicated that a savings of 0.23 percent of taxable payroll is "in essence" due to the fact that "receipt of benefits on more than one earnings record, results in a greater in-

crease in estimated income than in estimated outgo * * *". Translated freely, I take this to mean that "married working women" are paying more than their fair share into the social security system.

As to "fiscal soundness," however, it should be noted that the "actuarial status" of the social security fund has a net balance of "1.16 percent" of taxable payroll relative to the cash benefit payments.

I want to take just a moment of the committee's time to point out some of the worse effects of the present provisions. For more details, I would refer you to my remarks which appeared in the Congressional Record for March 17, 1969, starting at page H1773. These remarks were made in connection with a bill, H.R. 6500, which I and 42 others introduced to permit the computation of benefits for a married couple on the basis of their combined earnings record. Other Members have introduced comparable bills and have supported this legislation. More than 10 percent of the Members in the House now sponsor this provision.

Although many married women receive little or no additional benefits in return for the social security taxes they pay, there is an even worse situation in which a husband and working wife can pay the same amount in social security taxes as a husband whose wife never worked and get less in benefits than the couple where the wife never worked. For example, the benefit paid to a person with average monthly earnings of \$200 is \$101.60; thus when the husband and wife both have average earnings of \$200, the total monthly payment is \$203.20. On the other hand, the monthly payment to a man with average earnings of \$400 is \$153.60 and his wife, who has never worked can be paid an additional benefit equal to one-half of that amount—\$76.80—making the total monthly payment to the couple \$230.40, or \$27.20 a month more than is paid when the same amount was earned (and the same amount of taxes paid) equally by a husband and his wife.

I would urge this committee to correct this inequitable situation along the lines proposed in H.R. 6500.

Mr. Chairman, that is a nice round number, isn't it, 6500, when we are talking about people over 65.

H.R. 6500, however, is an expensive proposal, and in the light of the present fiscal situation and the need to set priorities, it may need to be modified so as to reduce costs. Should the committee find the bill too rich for the present situation, I urge you not to reject the idea. Rather, I suggest that you revise the formula in H.R. 6500 within the limits of available funds, to permit a married couple to get some additional return for the additional taxes paid on the wife's earnings.

INCREASE SOCIAL SECURITY RETIREMENT TEST

Out of practical experience, I would like to touch on another matter. I note that the Administration has recommended that the "social security retirement test" be changed so that a social beneficiary can earn as much as \$1,800 a year without having his benefits reduced. The present test with its \$1,680 amount is clearly at odds with today's wage levels. I have serious doubts, however, that raising the amount to \$1,800 is a significant improvement. I would suggest that a higher amount, say \$2,400 a year, would be a more reasonable amount when one considers the high wage levels which prevail.

DISABILITY INSURANCE BENEFITS

I would also urge the committee to give serious consideration to a proposal to liberalize the conditions under which disability insurance benefits are paid to blind people.

Mr. Chairman, my father was blind as a result of his work for over 30 years and I have an interest in this.

Mr. Burke of your committee and 27 other Members of the House have introduced measures similar to a bill, H.R. 11217, that I introduced. Sixty-nine Members of the Senate have introduced similar measures. In 1965 and in 1967 a similar provision was in the social security bill passed by the Senate and later dropped in conference. I would hope that the next social security bill sent to the floor would contain such a provision, so that the entire House would be given an opportunity to pass judgment on the provision.

Thank you for this opportunity to appear here today.

Mr. ULLMAN. Mr. Patten, you have raised very concisely three very important issues that have also concerned the committee. We appreciate your viewpoint.

Mr. Schneebeli?

Mr. SCHNEEBELI. Mr. Patten, I am particularly interested in your observations here with regard to married working women and there is at least one additional member of the committee, who I am sure will support you. Mrs. Griffiths has been advising us continuously of her interest in this matter, and I think the committee is very well aware of some shortcomings in this area. Mrs. Griffiths does an excellent job in this particular area of concern.

Thanks for pointing them out to us.

Mr. PATTEN. I might tell you that I have many thousands of petitions from organizations and individuals from my State and throughout the country and I showed them to your chairman, Mr. Mills, and others.

Mr. SCHNEEBELI. Mrs. Griffiths has been a very good advocate of the point you are making.

Mr. ULLMAN. Are there other questions?

Thank you very much, Mr. Patten.

Mr. PATTEN. Thank you.

Mr. ULLMAN. Our next witness is the Honorable Jorge L. Córdova.

Mr. Córdova, we are very happy to welcome you before the committee this morning.

STATEMENT OF HON. JORGE L. CÓRDOVA, COMMISSIONER OF PUERTO RICO

Mr. Córdova. Thank you, Mr. Chairman, members of the committee, for this opportunity.

I must bring to your attention certain aspects of the Social Security Act and of the proposed family assistance plan which are of particular concern to my 2.7 million constituents, your fellow American citizens, the citizens of Puerto Rico.

THE PROUTY AMENDMENT AND PUERTO RICO

First, I will address my remarks to the area of the special payments which in 1966 were authorized as part of the social security legislation for certain individuals age 72 and over, the so-called Prouty amendment. Under section 228(e) of the Social Security Act, those persons who reached the age of 72 before 1968 are eligible for a special monthly cash benefit even though they may not have earned any quarters of coverage. For those persons reaching the age of 72 between 1968 and 1972, a certain minimum coverage is required which is substantially lower than the 40 quarters of coverage normally required by the law. For those reaching age 72 after 1972 the usual fully insured status is required.

But my constituents, the citizens of Puerto Rico, are excluded from receiving these special payments. The unfairness of this geographic discrimination becomes apparent when you consider that the residents of Puerto Rico and their employees contribute to the old-age and survivors' insurance trust fund in the same measure as residents of any State. Yet they are not permitted to share in the benefits of the Prouty amendment, although the money they and their fellow Puerto Ricans contribute to the trust fund is used to extend some of the benefits of the Prouty amendment to people residing in any of the 50 States or the District of Columbia. I may add that residents of the Virgin Islands and Guam are subjected to the same discrimination as the citizens of Puerto Rico, in this respect.

An uninsured person over 72 who moves from Puerto Rico to the mainland is immediately eligible for the benefits of the Prouty amendment. And a resident of one of the States who is receiving the benefits of the Prouty amendment and moves to Puerto Rico becomes ineligible. One such person, who was entirely unaware that the privilege extended to the elderly by the Prouty amendment depends on residence in one of the States or the District of Columbia, recently wrote me to complain that, after several months of residence in Puerto Rico, her benefits were cut off, and she was being asked to refund several hundred dollars of benefits erroneously paid her before she revealed her change of residence by making the mistake of asking that her mail be addressed to Puerto Rico.

I have introduced a bill, H.R. 13399, to correct this discrimination which I am confident was not intended. I urge the committee to report this bill favorably. I need hardly say that most of the elderly folk who live in Puerto Rico need the benefits of the Prouty amendment as much as do the elderly folk who live on the mainland.

FAMILY ASSISTANCE PLAN

I turn now to H.R. 14173, the family assistance plan, and I address myself specifically to the provisions of section 464 of the bill which contain the formula for computing Puerto Rico's level of participation in the program.

Great strides have been made in Puerto Rico toward developing the economy of the island and toward attaining a substantial measure of distributive justice. Total jobs and wages have increased. A real middle class has developed, and is fast increasing. But in spite of the declining birth rate which we hope will bring our population into balance in the

near future, and because we have brought our death rate well below that of the Nation as a whole, our population continues to increase. Our birth rate has declined from 41.9 per thousand in 1945 to 24.8 in 1967, but our death rate has declined even more sharply during the same period, from 13.7 per thousand to 5.8. As a result, and in spite of a successful industrialization program, there continues to be a very serious unemployment problem, particularly among the unskilled.

The unemployment, and underemployment, of the unskilled in our island place us in the unenviable position of having a per capita income far lower than that of any of the States of the Union, and indeed far lower than the much less populous Virgin Islands, or Guam, a per capita income which, unfortunately, is only theoretical for many thousands of families in Puerto Rico. Thus pressures have developed which have resulted, and are resulting, in the migration of thousands of Puerto Rican families from Puerto Rico to the mainland, for the most part to the urban centers of the Northeast and the Midwest, a migration which is certainly not the solution to the problem, a migration which Puerto Rico has never encouraged, but which those least acquainted with its disadvantages, and least prepared to overcome them, feel impelled to undertake.

The family assistance plan, with its emphasis on manpower training, is therefore especially important to the disadvantaged in Puerto Rico. It is certainly as important to them as to the disadvantaged of any other part of the Nation.

While we regret that it has not been deemed expedient to extend to the disadvantaged in Puerto Rico a measure of help equal to that which H.R. 14173 proposes to extend to the disadvantaged elsewhere in the United States, we must acknowledge that the formula expressed in section 464 of this bill is an improvement on the present situation. The formula, in effect, provides that in the case of Puerto Rico the amount of benefits, the amount of resources and income to be disregarded and other amounts under the act will be reduced to the extent that per capita income in Puerto Rico is lower than that prevailing in the State with the lowest per capita income. This, of course, results not only in the reduction of the amount of benefits payable to each eligible family, but also in the reduction of the number of families eligible to receive benefits.

Limited as is the participation of the Puerto Rican poor in the family assistance plan, I support H.R. 14173 because I believe firmly in the principles of uniformity of treatment throughout the Nation to the recipients under Federal-State public assistance programs, and of incentives for employment and training as part of a family assistance program, and because I believe the provisions of H.R. 14173 regarding Puerto Rico are a good step in the right direction, and will be of great help in our efforts to achieve for all of our people a standard of living high enough to discourage in any of us any silly notion to leave our beautiful island in search of the bare necessities of life.

I thank you, Mr. Chairman.

Mr. ULLMAN. Mr. Córdova, this committee is always interested in your report on matters pertaining to Puerto Rico, and we appreciate very much your statement.

Are there question?

Mr. Gilbert?

Mr. GILBERT. I would like to extend a personal welcome to my friend, the Resident Commissioner of Puerto Rico, and compliment him on his fine statement here this morning.

May I say that I agree with you completely. I don't understand why you have this inequity and discrimination with respect to the elderly in Puerto Rico as opposed to the people in the States. I just never have been able to comprehend the reasons for it and I am hopeful that as we continue the discussions on social security, we will eliminate this discrimination.

Mr. CORDOVA. Thank you, Mr. Gilbert.

Mr. ULLMAN. Thank you very much, Mr. Cordova.

Mr. CORDOVA. Thank you.

Mr. ULLMAN. Our next witness is the Hon. John A. Blatnik from the State of Minnesota. We are pleased to have you with us today.

STATEMENT OF HON. JOHN A. BLATNIK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. BLATNIK. Mr. Chairman, and members of the committee, I appreciate this opportunity to speak in behalf of a more liberal revision of the social security program.

After 34 years of the social security system, nine out of 10 in this country who work for their livings are covered by social security benefits, and each month 25 million Americans receive over \$2 billion. If we add to this, those who receive medicare benefits, the sum covered by social insurance reaches 95 percent of the American working population. Clearly, the social security system, with its two related objectives—to guarantee minimum income support for the aged, disabled, and for dependent survivors, and to help moderate the decline in living standards when the earnings of the family head cease because of retirement, death or disability—has become an institution in this country, as essential means of existence for hundreds of thousands of people. For over half of all social security beneficiaries, this is their only source of income, and according to Government standards of poverty, this age group, the over-65 retired, comprise 20 percent of America's poor.

In the past year, however, we have seen a soaring rise in the cost of living, witnessed by a prime rate of interest last month of 5.8 percent. We have been informed by the Social Security Administration that next year medicare rates will have risen from \$3 in 1966, at its inception, to somewhat over \$5 just 4 years after. Hospital costs, in line with rising costs of living will jump from \$44 a day in 1969, to \$52 a day in 1970, and some estimates bring the costs of hospital care to \$100 a day by 1975, although in point of fact, several large hospitals already receive this amount for daily care.

One final set of statistics—Robert Myers, Chief Actuary of the Social Security Administration, in his cost estimates for the present OASDI system, showed a positive financial surplus of taxable payroll of 1.16 percent for this year. This means that the present system is considerably overfinanced, and, in fact, that the Presidential proposals for improvement of social security benefits are also overfinanced. In short, this means that we can afford considerably greater benefits than we offer at present, and certainly greater benefits than are asked for by the administration.

All these separate facts and figures add up to this: that the enormous majority of Americans are dependent—almost exclusively—on the social security system for income support and for sustained standards of living after retirement, disabling accidents, or after death of the head of the family. It means further, that these millions of Americans, in this period of inflation, will experience decreasing standards of living, less effective income support even if we keep benefits the same; even if we improve them only slightly. Finally, these figures show that we must provide liberally for increasing cost levels of living, increasing hospital costs, increasing drug costs, and that we can do this within the projected actuarial figures. The alternative to liberal improvement of our social security benefits in several areas will be to condemn those thousands of Americans to subpoverty level incomes and to a future of progressively increasing poverty for the rest of their lives.

The Nixon administration proposal, to increase social security benefits by 10 percent in April of 1970, and to provide annual cost-of-living increases is simply miserly, in the light of these facts and figures.

My bill, H.R. 11586 would help alleviate the growing income plight of the elderly by a three-step increase in primary insurance amounts across the board: 20 percent after December 1969; by another 20 percent after December 1970; and by 25 percent after December 1971. These increases will apply to lump-sum death benefits, and to those over 70 in the special category where they receive less than the full amount of coverage given to an individual with the requisite quarters of coverage. To the elderly retiree, these increases mean that his minimum monthly benefit will rise to \$99 in 1972, and that maximum monthly benefits by 1972 will be up to \$392. Overall, this is an increase of 80 percent in social security benefits, and in line with actuarial projections released by the Social Security Administration.

But increasing benefits can only be half of the solution to the problem outlined in my opening remarks. If we are to fulfill the purposes of the social security system, we must not only increase benefits but also establish a flexible system of automatic adjustments pegged to cost-of-living increases. We have seen the effects this year of skyrocketing prices. All of us have heard the voices of our retired and elderly constituents urging us to help them keep their heads above water. And we simply cannot make a token gesture, as I am afraid, the administration has done. The cost of living rises sporadically throughout the year, and, as we have seen this year, it can rise as much as 10 percent in just 1 month. We cannot hope to meet these fiscal demands by providing just a yearly increase in benefits. My bill proposes a far more realistic measure—automatic cost-of-living adjustments quarterly. This would mean that with every 3-percent increase in the price index in a quarterly period, the Secretary would be empowered to raise monthly benefits a like percentage. This provision, I believe, approaches a fair answer to the problem of inflation far more closely than a simple annual automatic increase, and assures to dependent beneficiaries a fighting chance to remain above the poverty level as the inflationary tide rises.

Since the last changes were made in the retirement test, we have seen a substantial increase in wages and prices, and we surely can expect the trend to continue. Consequently, my bill contains provisions to increase the amount a person can earn and still receive full

social security benefits. H.R. 11586 increases to \$275 a month—\$3,300 a year—the amount a retired individual can earn. Beyond this amount, his social security benefits are decreased on a dollar-for-dollar scale.

On another front, a great part of the burden of old age lies in the increased number and costs of drugs necessary to preserve health and comfort—and these drugs cost money. In fact, drug costs account for about 30 percent of private expenditures for health care by the aged person's health-care dollar. Yet very few health insurance plans offer protection against the cost of drugs. Further, we are becoming increasingly aware of the discrepancy which exists between the cost of generic and that of brandname drugs. My bill does two things to help solve these problems. First, it contains a provision extending the medicare program to cover 80 percent of the costs of qualified drugs, with a 25-percent deductible provision. Second, it establishes a formulary committee to determine which drugs would qualify under these provisions, and to publish a compendium of such drugs, with benefits to be based on the ultimate costs to the dispenser. This provision will give a fairer shake to our elderly, dependent on drugs for life and health, and ignorant of the simple economic fact that a brand label may cost 500 to 1,000 percent more than the same drug by a generic name. At the same time, it provides a safeguard to the medicare system, to assure that its benefits are purchasing highest quality drugs at the lowest possible cost.

Now, with all these liberal provisions, I know there has to be a price tag. And I have written in provisions which will pay that price. First, I have written an actuarially sound bill based on 1970 wage level assumptions, and providing step increases in benefits over a period of 3 years—based on projected wage levels for those years. Second, I have included a provision which increases the taxable wage base to \$10,000 in 1970, and to \$15,000 in 1972. This increased taxable wage base will affect altogether 18.7 million taxpayers by 1972 who are presently paying social security taxes on the first \$7,800 of their incomes.

Both provisions have the advantage that those most able to pay for social security benefits will be asked to pay, while those least able to bear an increased tax burden will contribute to social security at a rate no higher than that they now pay.

Mr. Chairman and members of this committee, I am confident that these facts—rising inflation, hospital costs, drug costs—are no news to any one of you. And I am equally certain that you are aware of the obligation we have to those 92 million people who contribute to the social security system, and most especially, to those 25 million Americans who are struggling to maintain their lives at levels which allow them respect and dignity in their old age. If we can improve their lot—and we can—then we must, and we must do so as liberally as possible. We cannot stop at halfway measures. We cannot be satisfied with a gesture, when gestures will not adequately provide simple necessities such as food, health care, and drug coverage. We have the opportunity now to carry out the objectives of the social security system when it was instituted more fully, more humanely, than ever before. With my bill, and with similar liberal measures, I know we will go far toward realizing those objectives, and I urge you most sincerely to give every consideration to these liberal revisions.

Mr. ULLMAN. We thank you for bringing us your views here today. Are there any questions? There are none. Thank you again.

Mr. BLATNIK. Thank you, sir.

Mr. ULLMAN. Mr. Meskill. Will you please come forward? We have with us Congressman Thomas J. Meskill from the State of Connecticut.

STATEMENT OF HON. THOMAS J. MESKILL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. MESKILL. Mr. Chairman, early in the session I introduced three social security bills which I would like to bring to your attention in your consideration of the President's proposal for amending our social security system. H.R. 5542 would provide a 13-percent increase in benefits across the board. H.R. 5543 adds a provision for an automatic cost-of-living increase much like that contained in the President's proposal. And H.R. 6252 would remove the earnings limitation on the amount of outside earnings which an individual may earn while receiving benefits.

No one can be oblivious of the steep increases in the cost of living. Nor can we delay any longer in up-grading those benefits by at least 13 percent for we know that cost-of-living increases bear most heavily on people with fixed incomes.

Currently the average monthly benefit for a retired worker is just about \$100, and studies have shown that for most social security beneficiaries this is the primary source of income—sometimes the only source. Today's dollar is generally held to have the purchasing power of 35 cents as compared with the 1940 dollar. The January 1968 dollar is now worth about 91 cents. And prices continue to rise. The September 1969 Consumer Price Index rose to a record 6-percent annual rate. Many retirees have planned carefully for their older years, but even the most careful plans can be disrupted by change and rising costs.

The total average payment for an aged couple is an even more inadequate \$168 per month, or \$2,016 per year. That is a little over \$5 a day—or \$2.50 each for husband and wife. On this meager amount many retired couples with no other income must buy food, clothing, and shelter, and any medical supplies they may need. Some people don't hesitate to spend that much for lunch. These senior citizens are the people who built our great industrial complex and have during their working lives produced the abundance the rest of us enjoy.

In addition to the 13 percent benefit increase, my bill would increase the minimum benefit from \$55 to \$62.20 and the lump-sum death payment from \$255 to \$290. Payments for those people past 72 who have little or no social security credits would likewise be increased from \$40 to \$45 for an individual and from \$60 to \$67.50 for a couple.

With this change I would also like to see enacted the automatic cost of living adjustment contained in the President's plan and in my bill H.R. 5543. Under this proposal, benefits will be adjusted to the cost of living without having to wait for the Congress to act, thereby shortening the period that people must wait for congressional action. And people would know what to expect. Such a device would take social security out of politics. Over 3 years ago, back in June 1966, the Republican coordinating committee made such a recommendation. In their view, between sporadic increases ranging from 5 to 13 percent:

There has usually been a time lag of several years during which the pensioners have suffered from a drop in their purchasing power. For example from 1958 through 1964 just before the 7 percent increase in pensions was legislated, inflation cost Social Security pensions approximately \$1.4 billion in loss of purchasing power.

When he appeared before this committee, Robert H. Finch, the Secretary of Health, Education, and Welfare, pointed out that in 1968 the platform of both political parties had recognized the need for such a change. He added:

Such an automatic adjustment system would increase the security of one out of every 8 people in the country who now receive monthly social security cash benefits. The automatic provisions would also adjust the benefits for the millions of future beneficiaries whose major source of income could well be their social insurance payments under social security. Because of the time lags that have occurred between past cost of living adjustment of benefits, the purchasing power of the benefits has been seriously decreased between benefit increases. With automatic adjustments, the changes necessary to restore purchasing power will be on a more current basis.

I heartily agree with him that this is very necessary legislation, and I hope the committee will find it possible to include such a provision in the bill when it is voted out and presented to the House for action.

The administration bill makes some changes in the earnings limitation by eliminating the two-step increase above the present \$1,680 which is exempted entirely. To further eliminate work disincentives in the retirement test, the bill exempts all earnings up to \$1,800 and provides for a \$1 for \$2 adjustment above this amount.

This is an improvement over existing law, but I would go a step further and eliminate the earnings test entirely, as provided in my bill H.R. 6252. Under existing law, with its cumbersome step increases, it is almost impossible for an individual to tell how much he can earn over the \$1,680 base, without paying a penalty in the form of repayment to the social security fund for benefits he has already received but must pay back because of faulty arithmetic.

Mr. Chairman, I have always believed that it is wrong to allow people to pay into the fund during their working life, and then, if they are well enough and ambitious enough to continue working beyond retirement age, be penalized for working. His neighbor, with an identical wage record, can get full benefits for the rest of his life without lifting a finger if he decides not to work. The man or woman who is working must also continue to pay social security taxes on the very earnings which can deprive him of at least part of his benefit payments.

In closing, I would like to endorse the President's new family assistance program. I particularly approve of the new national minimum for welfare payments—in effect, a fixed, basic income for every poor family, including the working poor. I approve of the fact that coupled with this would be a requirement that all able-bodied men and women on welfare, excepting some mothers with young children, receive work training and must take the jobs that are found for them. I approve of the provision that dependent families receiving such income be given good reason for going to work by making the first \$60 a month they earn completely their own with no deductions from their benefits because of earnings. I approve of the revenue sharing scheme to turn back about \$1 billion in Federal taxes to State and local governments. I like the expanded Federal manpower training

program. I agree with the President that "the present welfare system has failed us—it has fostered family breakup; has provided very little help in many States and has even deepened dependency by all too often making it more attractive to go on welfare than to go to work."

I hope the committee will include the recommendations I have suggested in the amendments it proposes to the Social Security Act.

MR. ULLMAN. Are there any questions of Mr. Meskill? Thank you, sir, for coming to the committee.

MR. REUTHER, the committee will be very happy to hear you at this time. I want to welcome you before the committee and express the regrets of both Mr. Mills and Mr. Byrnes at their inability to be here this morning. They had to appear before the Rules Committee on very pressing matters. We have had you before the committee many times and we always look forward to your presentation.

Would you please identify your colleague for the record and proceed as you see fit, sir?

STATEMENT OF WALTER P. REUTHER, COCHAIRMAN, ALLIANCE FOR LABOR ACTION; ACCOMPANIED BY MELVIN GLASSER, DIRECTOR OF SOCIAL SECURITY DEPARTMENT, UAW

MR. REUTHER. Thank you, Mr. Chairman. Appearing with me is Mr. Melvin Glasser, who is the director of the social security department of the UAW.

I appreciate the opportunity of appearing before your committee, and while I come here as president of the UAW, I am here primarily as cochairman of the Alliance for Labor Action, a position that I am privileged to share with Mr. Frank Fitzsimmons of the International Brotherhood of Teamsters.

The Alliance for Labor Action represents approximately 4 million American wage earners and their families and, obviously, we are deeply concerned with the matters that are presently before your committee.

I would like, if I might, Mr. Chairman, to put what I want to say in the broad context of what I think is the central problem facing our society. I think that each of us is aware of the fact that we live at a time of revolutionary changes and challenges and that this indeed is a time of testing for free men and our free institutions.

We are the richest nation in the world. In a couple of years we will have a gross national product in excess of a trillion dollars. That is almost incomprehensible. We have the most productive economy. We have the most highly advanced technology. But I think we need to look within ourselves and realize that history is not going to judge the quality of American society by our material wealth nor by our productive power, nor by the level and sophistication of our technology, nor by the brightness of the chrome on the new Cadillacs that we turn out in Detroit by the tens of thousands.

I hold the view that the true measurement of the quality of any society is not how rich it is but how it orders its priorities, how it allocates its resources, and how it pursues its national purposes in raising living standards, in educating the young, in providing security and dignity for the old, in improving living environments, in assuring

access to adequate health care to every person as a matter of right and not as a matter of privilege, and how that society in general facilitates the growth and the fulfillment of each individual. And what you are talking about in your committee now, as you give consideration to the revision of what is, I think, perhaps the single most important piece of social legislation in our country's history, will have a great impact upon the quality of American society.

We are in trouble, I believe, in America, not because we lack the resources or the knowhow to deal effectively and meaningfully with the urgent human and social problems that confront our Nation; we are in trouble, Mr. Chairman, because our values are out of focus. There is a lot of high-octane hypocrisy in America. People say they believe in things but they never believe in them strongly enough to do anything about them. We have been too much concerned about the quantity of our goods and too little concerned about the quality of our goals.

I think that your committee and all of us need to work to help America to reorder its priorities so that we can put first things first and commit ourselves and our resources to translating those priorities into practical programs of fulfillment.

Now, on Friday of this week, we will all be watching television and in the heart of every American there will be a prayer that the Apollo 12 mission will be as successful as Apollo 11. But we need to ask ourselves how it was possible for Neil Armstrong to leave man's footprints on the surface of the moon. It was not, I believe, solely because America has tremendous technological and scientific capability, although we do have that; it was also because America made a national commitment to go to the moon. Having made that commitment we gave of both ourselves and our resources in a measure sufficient to enable Neil Armstrong to leave man's footprints on the face of the moon. Until we make a comparable commitment to deal with the urgent human and social problems here at home, we are going to fail to find adequate solutions.

I would urge that we make, as a nation and as a people, the provision of economic security and human dignity to our older citizens a matter of the highest priority on our unfinished agenda. Despite the fact that we are the richest nation in the world, millions of our older citizens spend the autumns of their lives living below the poverty level, when those years should be the golden years that give them the kind of rewards a free society ought to give its citizens for having lived useful and productive lives.

Some of the poor grow old, but many of the old grow poor because they are subjected to a social security system which is not adequate to meet their needs.

I believe that if we look at the values that we profess to believe in, values of a free society that respects the worth and the dignity of every human person, then we must conclude that there can be neither economic justification nor moral defense for the richest nation in the world to deny its older citizens that measure of economic justice and human dignity to which they are entitled.

Poverty among the old is most tragic because they have outgrown the economic capability of escaping that poverty. A young person living in poverty has the opportunity, through education, training and upgrading his skills, to escape from poverty, and we ought to

assist him in every way possible. But an older person who has lived beyond his productive years is a prisoner of the poverty in which he is trapped.

The President's message on social security was most disappointing to us, but we also believe that recommendations for a 15-percent increase in current social security benefits are inadequate.

We believe that we have to acknowledge that while social security legislation now has been on the books for more than a third of a century, we have still failed to achieve the modest goals of the Cabinet committee that developed the first social security legislative proposal advanced by President Roosevelt. We have failed to achieve adequate safeguards against all of the hazards leading to destitution and dependency.

The bill by Congressman Gilbert, H.R. 14430, is, we believe, the most nearly adequate of the many social security proposals now before the Congress, but even that, we believe, requires some improvement. We believe we must of necessity go beyond the recommendations of that bill if we are to deal with the economic reality of the basic needs of America's older citizens. Therefore, Mr. Chairman, we specifically recommend that the minimum monthly benefit for a worker who retires at age 65 be increased to \$100 in January 1970, be stepped up to \$110 in January of 1971, and to \$120 in January of 1972. Similarly, we recommend that an elderly couple, both with benefits starting at age 65, would have a guaranteed, combined minimum benefit of \$150 in January of 1970, with further increases to \$165 in 1971, and \$180 in 1972.

We recommend, further, a general increase in the level of benefits of at least 50 percent in all benefits payable above the proposed new minimums that we suggest. Such increases are long overdue and would move us in the direction of what we believe must ultimately be the goal for social security legislation; that is, to provide a wage earner in his years of retirement benefits that approximate two-thirds of his earnings in the years before retirement. Even a one-third reduction in his income is going to subject him to certain economic problems.

We also recommend that the base for covered earnings be increased to \$15,000 and that this be done in several steps. The \$9,000 figure proposed by the administration is totally unrealistic. In 1935 when the first social security legislation was enacted, wage earners had roughly 95 percent of their earnings covered by the system. Although the original \$3,000 base has been raised on five occasions, the relationship of total earnings to covered earnings has continued to deteriorate. If we were to have a \$15,000 base now, we still would not achieve the same level in terms of total coverage that we had in 1935.

There are numerous recommendations that we spell out in our prepared statement. I would appreciate having them made a part of the record, and I would like to cover several of them very briefly.

Mr. ULLMAN. Without objection, we will have your statement appear in its entirety in the record.

Mr. REUTHER. Thank you.

I will just touch upon a few of the more important ones.

We believe that a social security system that is really geared to the needs of our older citizens has to have a built-in cost-of-living adjustment because, as we know, as wage earners, it is not what we take home

in our paychecks that matters; it is what we can buy with them. It is not the number of dollars that a retired worker gets in his social security check; it is what he can buy with that. Therefore, we believe that he ought to be protected by a cost-of-living adjustment.

Further than that, we believe that every retired worker ought to have the right to share in the real growth of our gross national product made possible by technological advances. A share in the fruits of these gains ought to be factored into the social security benefit formula.

We also believe, Mr. Chairman, that it is time that this country of ours recognizes that any social security system relying exclusively, or almost exclusively, on a payroll tax, unavoidably places a disproportionate share of the burden of financing benefits upon the backs of younger workers just beginning to raise their own families and meeting all the problems that entails. We are almost the only industrialized democratic country in the world that has relied so heavily on a payroll tax. Nearly every other country in the democratic world has had the good sense to pay a sizable proportion of social security costs out of general revenues with the balance being shared in some fashion by the employers and the workers.

Therefore, we would urge that the Congress give consideration to begin to shift some of the burden of social security costs away from the payroll tax to general revenues and in stages ultimately achieve a balance by which the employer, the employee, and general revenues each bear approximately one-third of the total cost.

There is a matter I would like to raise very briefly that is not technically before your committee, but I think it is a matter that the Congress has to give serious consideration to. We are one of the few countries in the world which, while relying primarily upon the social security system for retirement income, at the same time, also supplements that by privately negotiated pension plans. Because we work within the framework of a market economy we are sometimes faced with the very serious and tragic situation of a worker who has looked forward to, and planned his retirement years with the expectation of receiving a certain portion of his retirement income from social security and another portion supplementing social security from a privately negotiated pension plan, only to find that, because of marketplace forces, his company has gone out of business, and left him high and dry without a pension. We believe that with a very microscopic premium contribution from qualified pension plans, spread over the whole economy, we can reinsure those benefits, just as we reinsure bank deposits. In that way we can avoid the tragedies of plant closings that leave workers without the benefits that they had planned on to sustain them in their years of retirement.

I would like to conclude by making some general observations about the health care problem.

Your committee has before you the problem of medicare and medicaid. The cost of both of those programs is skyrocketing, and I think that we need to realize that we cannot solve the problem of medicare or medicaid in a vacuum. They can only be solved within a framework of a more rational organization of our total health care programs.

Mr. Glasser, who testified for the UAW, in this area, has made a number of what we think are very significant and meaningful recommendations. I want to support those recommendations, but I

would like to direct my remaining remarks to the broad question of health care.

President Nixon some weeks ago in addressing the Nation on the health care problem warned that unless we bring about massive change by legislation and other action, our health care system would collapse in a couple of years. He was right.

There are hundreds of hospitals all over America that are in deep crisis and struggling month after month just to keep their doors open. Almost every year Blue Cross and Blue Shield knock on the door of the insurance commissioner in nearly every State, saying, "We need an 18-percent, 19-percent, 22-percent increase in the level of Blue Cross-Blue Shield premiums." Our crisis in health care is getting more serious every day as the cost of health care services are skyrocketing at twice the rate of increase of the general Consumer Price Index which is going up rather steeply itself, as we know.

In 1969 we will spend \$60 billion for health-care services. This represents the second largest expenditure from our gross national product, second only to what we spend for military purposes. Yet having spent \$60 billion, the American people are getting second-rate health care services. We have the highest level of medical competence of any country in the world. No other country even remotely approaches our level of medical competence and sophistication. We are spending more money for health care than any country in the world and yet a World Health Organization report issued about 3 weeks ago shows that America ranks 26th among the nations of the world in terms of life expectancy for men, 12th in life expectancy for women, and 14th in the rate of infant mortality. I say that these are shameful, shocking health facts in the richest Nation in the world with the highest level of medical competence.

The basic problem is that the American consumers—and I sit at the bargaining table and we have bargained for more than two and a half billions of dollars of health-care services in the contracts that we have—are being asked to subsidize the waste and the inefficiencies of a disorganized, disjointed, obsolete "nonsystem." Pumping in billions and billions of dollars more will not solve the problem. What we need in this country is to bring about a restructuring of the health care delivery system so that we can have a more rational and more efficient use of our manpower, our facilities, and our resources and so that we can begin to provide Americans with comprehensive high-quality health care as a matter of right and not as a matter of privilege.

For more than 20 years we, and the employers with whom we negotiate, have sat at the bargaining table along with the representatives of the largest insurance companies in America. We have worked cooperatively with them and they have worked effectively to try to deal with the problem of how a free society makes available health-care insurance to its people so that they can have adequate protection against the hazards of illness and accidents. But the insurance industry has failed, Mr. Chairman, for the simple reason that they could not control the cost of health care. They are just collecting agencies. They have nothing to do with controlling costs. They have nothing to do with controlling the quality of services. And their 20-year effort has demonstrated that they are incapable of providing universal health insurance protection.

Twenty-four million Americans, after 20 years of effort by the private insurance industry, still have no health insurance whatsoever. Thirty-five million Americans have no insurance for surgical benefits. Sixty-one million have no in-hospital medical insurance. Eighty-nine million Americans have no out-of-hospital X-ray or laboratory insurance. And 102 million have no insurance to deal with office calls or home visits.

So that after 20 years of the private insurance industry's tremendous efforts, millions and millions of Americans are left without adequate health insurance coverage. We are the only developed Nation in the free world that relies upon the marketplace to provide health-care services. Now, the marketplace does wondrous things in America, in providing gadgets, but it is incapable of responding adequately to assure essential human rights and needs such as health-care services. I think that we have to recognize that in no area of our national life is there a greater gap between promise and performance than in health care.

I am privileged to serve as the chairman of the Committee of One Hundred, who are working to achieve a national health insurance program. We believe it is time that this country recognizes that only by building a national health insurance program that will begin to create the economic base for the restructuring of our health-care system, in order to use our manpower and our facilities and our resources more rationally and more effectively, will we be able to provide universal, comprehensive, high-quality care to all of the American people. Our committee is made up of leading citizens from every walk of life, but the largest professional group is composed of doctors who have joined with us because they, too, believe that the marketplace will not give us the answers to this urgent problem. Dr. Michael DeBakey, with whom I had dinner last evening, is one of the vice chairmen and we have a large group of very distinguished physicians.

We believe that national health insurance is an idea whose time has come and we believe that we must look at this not as a matter of choice but as a matter of necessity. We make it very clear that we do not propose to borrow or to transplant the health insurance system of any other nation. We believe that America has the ingenuity and the social inventiveness to develop a uniquely American system that will preserve the best features of what we now have, but will overcome the shortcomings, waste and inefficiencies, in the present nonsystem. And I think that Congress, of necessity, has to come to grips with this problem. I would, therefore, urge as strongly as I can, Mr. Chairman, that the House Ways and Means Committee, which has a responsibility in this area, schedule extensive hearings early in the next session of Congress so that the American people will have an opportunity to discuss before your committee this basic problem: how a free society goes about achieving a rational organization of its facilities to provide high quality comprehensive care to all of the American people. I would urge very strongly that such hearings be called by your committee early in the new year.

There are many, many urgent problems that we need to face up to. Social security is one. Health care is another. Housing and education are others. There is a long list.

I want to say that my whole experience working with people has given me unlimited faith in the capability of free men and our free institutions. I believe, despite the difficult problems we face, that America is equal to the challenge and that America will respond to a call to greatness. I would urge your committee in its work to help America reorder its priorities so that we can put first things first. I would urge that you help us make social security, at adequate levels of benefit, and adequate health care, among the highest matters of priority on America's unfinished agenda.

Thank you.

(The prepared statement referred to follows:)

STATEMENT OF WALTER P. REUTHER, CO-CHAIRMAN, ALLIANCE FOR LABOR ACTION

My name is Walter P. Reuther, I am appearing on behalf of the Alliance for Labor Action, the chairmanship of which I share with Mr. Frank Fitzsimmons of the International Brotherhood of Teamsters. I am pleased to have the opportunity to appear before your committee to present the views of ALA on prospective Social Security legislation affecting monthly cash insurance benefits and to urge that this nation establish a new universal program of National Health Insurance. Our organization is also deeply concerned with both the health insurance title and the various welfare and assistance titles under the Social Security Act, but I am relying on my colleagues in the labor movement to speak on these matters in behalf of America's workers. Only because the scope of these hearings is so broad, have I chosen to limit my own remarks to the subjects indicated. My statement is divided into two parts. The first deals with the need for substantial revisions and improvements to the present cash insurance benefit provisions of the Social Security Act. The second part is a discussion of the current health care crisis in America and our recommendations for coping with that crisis with a national program of health insurance.

I. SOCIAL SECURITY INCOME INSURANCE PROGRAMS

Monthly cash insurance benefits paid under Title II of the Social Security Act are the major source of income for most of the nearly 25 million Americans now on the benefit rolls. But from the inception of the program to the present time, benefits have been chronically inadequate. We have made considerable progress towards achieving nearly universal coverage for the working population and broadening the scope of the program, but even after repeated liberalizations, we have failed to provide sufficient retirement income to assure the security and dignity to which American workers are entitled after a lifetime of work. The result is that millions of older persons are living in poverty.

Members of the ALA and their leaders believe that a free and abundant economy can do better than provide existence at the bare margins of subsistence for workers ceasing active employment because of old age or disability and for their families and survivors. The goal of our Social Security system should be to assure wage earners upon retirement of income from the public program equivalent to at least two-thirds of average covered earnings in the years before leaving the work force, with regular adjustments in benefits to reflect changing economic conditions. Such a program supplemented by private group pension plans, is needed to assure a standard of comfort, decency and dignity which workers in America have a right to expect.

Important new measures are required now to achieve practical improvements in Social Security programs. Both the Administration and the majority party proposals fail to deal adequately with these problems, particularly those affecting the poorest and the most disadvantaged. Accordingly the ALA, in behalf of four million working members and a half million retired members and of their families recommends the enactment of the following program by this Congress.

1. Guaranteed minimum monthly benefits as follows:

(a) \$100 for a worker retiring at age 65, effective January 1, 1970; \$110 for a worker retiring at age 65, effective January 1, 1971; \$120 for a worker retiring at age 65, effective January 1, 1972.

(b) Identical minimums for disabled workers.

(c) For elderly couples, both age 65 or over:

\$150 effective January 1, 1970

\$165 effective January 1, 1971

\$180 effective January 1, 1972.

2. An immediate increase of not less than 50% in current and prospective benefit payments applicable throughout the range of covered earnings.

3. An increase, by means of several broad annual steps, in the contributions-covered earnings base to \$15,000.

4. Provision for automatic adjustments in benefit payments to reflect not only upward changes in consumer prices but also to enable beneficiaries to share in the growth of the American economy as evidenced by advances in real wages and improved living standards.

5. An immediate Federal Government contribution to the Social Security Trust Funds from general tax revenues and subsequent contributions from general revenues on a gradually increasing basis, ultimately sufficient to provide an approximately equal sharing of costs among workers, employers and government.

6. Increased benefits for an elderly widow payable on the basis of 100% of her deceased husband's entitlement.

7. Male retirees should be given equal treatment with women in being able to exclude retirement years after 62 in computing average Social Security earnings. In any case benefits should be computed on the basis of the ten years of highest earnings.

8. Recognize and protect the essential complementary role of private pensions through adoption of Federal private pension reinsurance.

9. Adopt specific Administration proposals to provide Social Security earnings credit for certain periods of military service, to pay benefits to dependent parents of retired and disabled workers, to raise to 22 the maximum qualifying age for childhood disability benefits, and to pay full benefits to eligible persons in the year they reach age 72 without regard to their earnings in that year.

10. Revise certain restrictive provisions of the 1967 amendments to the Social Security Act in order to provide full benefits, without regard to age, for disabled widows and widowers; remove the ceiling on the spouse's insurance benefits to permit payment of a full 50 percent of the worker's primary benefit to the spouse; apply to widows and widowers the same definition of disability used to determine a worker's disability; and eliminate the geographical considerations introduced for establishing a worker's disability.

II. HEALTH CARE PROGRAMS

The "non-system" by which health care is provided in the United States is in crisis. The cost of health care is skyrocketing. We are channelling ever greater resources into the purchase and supply of health care, yet it is clear that many Americans are simply not receiving high quality health care, the opportunity for which every individual should have as a basic human right.

This nation possesses the resources, the know-how and the skills to make available the finest, most advanced standard of health care in the world. We have failed to fulfill our potential. Our failure is reflected in rates of death, for example, for mothers in childbirth, infants, and males between ages 40 and 50, that are higher than those of many less affluent nations. What is particularly shameful is the fact that these and other measures indicate a widening gap between the "haves" and the "have-nots" of this country in the quality and quantity of health care received.

Our "non-system" lacks both an understandable and accessible structure of organized health care services as well as effective systems for delivering health services. Pouring additional funds into the "non-system" through private insurance, government programs such as Medicare and Medicaid and increased consumer spending cannot make it work more effectively.

The ALA believes that only a comprehensive nationwide program of health insurance as part of the Social Security system can provide the reliable and equitable financial base needed to marshal and expand our health resources to assure the delivery of the full range of preventive, curative and rehabilitative health services to all Americans.

Because of the urgency of the crisis, Congress should begin now to consider the most desirable and effective approaches to assure timely achievement of such a program.

OLD AGE, SURVIVORS' AND DISABILITY INSURANCE AND HEALTH CARE PROGRAMS

We live in a troubled world. From all corners we hear protests at injustices, real and fancied. Some are peaceful, others divisive and provocative and some, as

we know, violent. There are also persons whose valid grievances go largely unheeded, who do not demonstrate and who wait patiently for equitable consideration of their problems.

This nation urgently needs a new perspective from which to reorder its priorities and to get on with the job of meeting the problems that are threatening to tear it apart. Any national action agenda for progress must deal with the problems of the nearly 25 million Americans, young and old receiving OASDHI (Social Security) cash insurance benefits and recognize the importance of bringing to all Americans the best opportunity for good health and life itself that modern medical science can offer.

I think we understand these problems and we have the know-how and the resources to deal with them. If we see our goals clearly, our potential is unlimited.

I have said on many occasions that the quality of our society will be judged by neither the measure of our material wealth nor by our productive potential, nor by the level of our technological progress, nor by the quantity of our gadgets, nor by the brightness of the chrome on the new Cadillacs and Continentals we turn out in Detroit. The real quality of a society should be measured by how that society orders its priorities, allocates its resources, and demonstrates both the sense of social and moral responsibility needed to translate technical progress into human progress and in finding answers to basic human and social needs.

I. SOCIAL SECURITY CASH INCOME BENEFITS

My remarks are centered mainly on the needs and problems of the 75 percent of Social Security beneficiaries who are 62 or older. Inadequate benefits pinch with similar discomfort the rest of the beneficiary population. I dwell mainly on the older groups only because there are so many of them and because I know that solutions to their problems will be reflected in comparable progress for younger beneficiaries.

On behalf of the Alliance for Labor Action whose membership includes 4 million active and 500,000 retired workers, I must tell the members of this Committee of my profound belief that the President's Social Security Message (H. Doc. No. 91-163) was a disappointment. You should know, too, however, that the alternative proposal of some members of the majority party for a 15 percent increase also falls far short of meeting demonstrable needs.

I want to emphasize that these feelings of disappointment are not confined to our older and retired members. Approximately 35 percent of the membership of the UAW is under age 30, but their interest in adequate and survivor protection is no less keen because of their youth. I do not exaggerate when I tell you that in my meetings with UAW members throughout the country I find both young and old are equally fervent about putting the need for adequate, decent retirement and survivor benefits near the top of our nation's and Union's goals. Others in the leadership of UAW tell me their experience is similar.

Obviously, a modest improvement at this time is more desirable than none at all. But we need to do better, both because we can and because the indisputable truth is that Social Security benefits have been chronically and persistently inadequate since the day the first check was issued.

It is also fitting to recall that retirement benefits for Federal Government employees, as well as members of Congress, were recently improved substantially. In an article by Vincent J. Burke appearing in *The Detroit News* for October 23, 1969, these improved retirement benefits, which include a 42% increase in maximums, pensions based on the highest three years of earnings, cost-of-living "plus" escalators—financed in part from general government revenues—were characterized as "the sweetest pension deal ever". I have also heard that the President has conceded that the improved benefits are not inflationary. We in the ALA are genuinely pleased that our public servants can look forward to their retirement with reasonable confidence of economic security and dignity. We believe they have earned those assurances, but we also believe that millions of American workers are deprived of even a modest degree of economic security in retirement because of Social Security laws are archaic, backward and unresponsive to the changing requirements of a growing economy. We think that Congress should begin now to make real improvements in the system.

The tragic experience of the depression of the 1930's taught this nation more about economics than the century and a half of our history that preceded it. One myth prevalent in the 30's, with roots buried deep in our past, still colors

our thinking and prevents us from dealing realistically with some of our current problems. I refer to the belief which has it that people are never poor because they are denied opportunity or because they are overwhelmed by events beyond the control of any person, but only because of some defect of character.

It is a comforting delusion for anyone who is economically self-sufficient because it justifies no more than minimal concern for members of the community who are dependent. It is not very useful as a guide to shaping legislation as all of you know from your efforts to solve America's current urban problems. The myth lingers, however, in our consideration of social security legislation.

We cling to the concept of Social Security as a basic floor of protection. Only grudgingly do we acknowledge the need for modest wage-related supplements above that level for workers whose earnings exceed the amount required to qualify for the minimum. We assume implicitly that Social Security when added to "something else"—the else is rarely specified—will permit a decent and reasonable level of living in retirement. If we accept the myth, it follows that anyone who, at retirement, has failed to accumulate the necessary "something else," deserves no more than what he receives, supplemented only by the least amount needed to keep him from starving or dying from lack of medical treatment. For all the others, we can discharge our responsibilities by seeing to it that Social Security benefit increases do not lag too far behind increases in the cost-of-living.

It is a lovely fairy tale that bears no resemblance to life in retirement in America on the eve of the 1970's. If you are unwilling, as I am unwilling, to accept the idea that, as a people, we are in large measure slothful, lazy, willfully ignorant or imprudent, the floor of protection is no more than a cruel hoax. For too many for our comfort, the floor of protection and "something else" add up to a bed of nails.

The economic status of Americans living in retirement is shameful. There is extensive documentation, of which members of this Committee are well aware, to support each of the following statements:

1. Poverty and near poverty are widespread among our retired citizens. Of all persons living in poverty, the aged are a much higher percentage than they are of the total population. Even as we progress in attacking poverty, we find an increasing proportion of older people among those who remain poor.

2. For those above the poverty line, the margin is often scant. That margin has been shrinking at an alarming rate during the past two years.

3. Relatively few persons past 65 have the opportunity and capacity for continuing employment. For those who remain at work, earnings decline with advancing age. For the great bulk of persons over 65 who either do not work, or work very little, Social Security benefits are the major, often the sole, source of regular and continuing income.

4. Income, if any, from private pension plans is small for the current generation of the aged. Current projections offer hope for only limited advances in retirement incomes from this source over the next 10 years.

5. While we know that many retired persons have assets of all types, the neediest of the aged have virtually none. Even those with considerable assets often hold them in a form that is not convertible to income or cash (most commonly a home).

6. The level of Social Security benefits has lagged behind both costs and standards of living. The gap in income between those working and those in retirement is widening.

Surely there is something drastically wrong when, after more than a third of a century, the largest and most important social insurance program of the wealthiest and most powerful nation on earth has never yet achieved the modest goal suggested by a Cabinet committee when asked by President Franklin Roosevelt to make recommendations to provide "some safeguard against misfortunes which cannot be wholly eliminated in this man-made world of ours." The goal enunciated by that committee reads:

"The one almost all-embracing measure of security is an assured income. A program of economic security as we vision it must have as its primary aim the assurance of an adequate income to each human being in childhood, youth, middle age, or old age—in sickness or in health. It must provide safeguards against all of the hazards leading to destitution and dependency."¹

The failings of our system of contributory social insurance are deep seated. They will not be cured by one more catch-up cost-of-living increase and by linking future benefit increases to changes in the consumer price index.

¹ "Report to the President of the Committee on Economic Security," 1935, p. 3.

Because the problems are deep seated, we need fundamental reform. We need to adhere to the goal we set in 1935. We need to do that in a way which does not further divide this country, that does not pit young against old. We cannot fairly ask young people, struggling with the burden of starting and raising a family, to shoulder ever increasing payroll taxes. No longer can we fairly consign the aged to a future of poverty.

If we have the will, we can solve these problems. They are more readily soluble than, for example, those of achieving equal opportunity for all Americans in education, housing, employment and health care. A reasonable, decent and dignified level of retirement living does not require a restructuring of society or a rethinking of our principles and values. I do not think I oversimplify when I say it is essentially only a matter of money.

I believe firmly that we must reshape our Social Security system through the following measures:

A. We recommend revised minimum benefits to provide:

(1) *\$100 per month effective January 1, 1970; \$110 per month effective January 1, 1971; \$120 per month effective January 1, 1972 for all workers retired at age 65 or retired for disability.*

(2) *Comparable benefits of \$150, \$165 and \$180 for elderly couples with benefits beginning at age 65.*

(3) *Corresponding adjustments in minimums to be made in family and survivor benefits derived from the worker's primary benefit.*

At the end of 1968, 17% of all retired workers were receiving the present monthly minimum benefit of \$55 or, if retired before 65, less.²

They are the poorest persons receiving cash insurance benefits. They include, in addition to workers whose early employment history was outside of Social Security coverage, a disproportionate share of black workers, farm workers, and workers who could not compete effectively in the employment market.

I have never been able to understand how this country, in view of its enormous money commitment to the principle of social insurance, the warm popular acceptance of that principle, and the suspicion and distrust with which so much of the public regards welfare programs, has consistently failed to set reasonably adequate minimum benefits for any of its social insurance programs. As a consequence, it has been common to attempt to supplement social insurance benefits with various forms of public assistance. But public assistance as it has developed in this country, because of its gaps, omissions, varying standards and eligibility and the refusal by many of the poor to accept the stigma of the means test, is simply not an adequate, effective or appropriate substitute for social insurance.

In February 1969, almost three fifths of persons receiving Old Age Assistance (OAA) payments were also cash insurance Social Security beneficiaries. According to a report issued from the National Center for Social Statistics, there were 1,181,000 persons simultaneously receiving OAA and Social Security cash benefits. This total was 58.2 percent of all those receiving OAA. The average monthly Social Security benefit was \$63.10 for this group which also received an average OAA payment of \$59.30.³

A basic requirement of a rational, effective Social Security system is a minimum benefit that offers some meaningful level of protection. In fact, it is entirely reasonable to suggest that the minimum benefit should not be any lower than the officially defined poverty level which, I understand is currently set at \$1,800 for a single individual and \$2,200 for a couple. Our proposal for minimum benefits falls short of that, but represents a major move in the right direction. It would remove hundreds of thousands of senior citizens from the welfare rolls.

Clearly, significant action on minimums must rank among the highest priorities on our agenda for reform.

The Administration proposal entirely ignores this problem. It would end up with a \$61 minimum simply by applying the proposed 10% increase to the present \$55 and rounding that to the next highest whole dollar.

² Information furnished by Social Security Administration from a compilation of State and county OASDI statistics.

³ "Concurrent Receipt of Public Assistance Money Payments and Old Age, Survivors and Disability Insurance Cash Benefits by Persons Age 65 or Over, 1948-69 and February 1969." U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, National Center for Social Statistics.

PROPOSED BENEFITS (ANNUAL) REFLECTING INCREASES IN MINIMUMS

	Current	1970 (\$100 monthly minimum)	1971 (\$110 monthly minimum)	1972 (\$120 monthly minimum)
Single.....	\$660	\$1,200	\$1,320	\$1,440
Worker with spouse ¹	990	1,800	1,980	2,160

¹ Both retired at age 65.

A Social Security minimum that is only two-thirds of the Old Age Assistance minimum (\$90 as proposed by the Administration) should be unthinkable. The alternative is not to lower the \$90 assistance figure, because that is really too low, but to raise the Social Security minimum to the level we are suggesting.

B. We recommend a general increase in benefits, payable above the proposed new minimums, of at least 50% in current and prospective payments, based on the full range of the worker's covered earnings, for worker and dependent or survivor beneficiaries.

In addition to an adequate minimum for those with the least earnings, a system that is appropriate for the wealthiest nation in the world should provide the opportunity for benefits above that level for workers whose earnings are greater.

For benefits above the minimum, the wage related concept built into Social Security enjoys wide appeal and acceptance. It gives meaning to a worker's feelings of equity and fairness to know that benefits rise as he contributes more. It provides a *national* retirement system in which all participants have a significant stake.

It is not enough, however, for a system to have a formal relation to earnings. The form must have substance. It loses value when large numbers of the best-paid workers find an ever-decreasing proportion of their total earnings protected and when workers with average earnings discover that their benefits fail to provide the basic foundation for achieving even modest economic security in retirement.

I believe that any fair appraisal of the performance of Social Security would have to conclude that it is, in fact, failing to provide such a foundation. What is happening is indicated by the following quotation from a task force report to the Senate Special Committee on Aging:

"Three out of 10 people 65 and older—in contrast to one in nine younger people—were living in poverty in 1966, yet *many of these aged people did not become poor until they became old.*

"An additional one-tenth of our aged population was on the poverty borderline. and

"The overwhelming proportion of people retiring today receive total pension income—from both public and private pensions—which is only 20 to 40 percent of their average earnings in the years prior to retirement."⁴

What a mockery! To grow old, so that one may become poor. Is that the hope America offers? Is that the reward for a lifetime of work, raising a family, contributing to the community, and paying taxes?

The increases of 10 or 15 percent now being proposed are not of sufficient magnitude to do the necessary job. They do little to maintain benefits in an appropriate, livable relation to pre-retirement earnings, to provide a fair return to beneficiaries for their contributions, to avoid forcing the majority of retired persons to forego even the modest levels of comfort and self-sufficiency they attained while working and to assure all Americans that retirement is not a ghetto whose inhabitants are forever barred from a share in the growing abundance of the American economic system.

On a number of occasions, I have said that our Social Security system should have an ultimate goal of assuring wage earners of retirement income from the public program equivalent to at least two-thirds of average earnings in the years before leaving the work force. In the long run, I believe such a goal is practicable and attainable. For the present, however, we can make progress with a far less ambitious objective. It would be reasonable, for example, to suggest that an average retired couple should be able to live at the level described by the U.S. Department of Labor "moderate" budget.

⁴ "Economics of Aging: Toward a Full Share of Abundance, a Working Paper," U.S. Senate, Special Committee on Aging, 91st Congress, 1st Session, pps. VII and VIII (emphasis in original).

This budget which takes into account rising prices requires an income of \$2911 to meet the lowest standard, and \$4,204 to meet the intermediate standard.

Our proposal would bring the average benefit for a retired couple to only slightly above the Labor Department's lowest level. For the newly retired couple with a worker who had average earnings in manufacturing industry, our proposal would make possible the intermediate standard. ("Three Budgets for a Retired Couple", Bureau of Labor Statistics, Department of Labor).

EFFECT OF PROPOSED 50-PERCENT INCREASE AND HIGHER MINIMUMS ON CURRENT AVERAGE SOCIAL SECURITY BENEFITS

	Current (1969)	Proposed (1970)
Single worker.....	\$1,200	\$1,920
Worker with spouse.....	2,016	3,225

RELATIONSHIP OF PRESENT SOCIAL SECURITY BENEFITS TO ALA PROPOSED INCREASES IN MINIMUMS AND 50-PERCENT INCREASES ACROSS THE BOARD

	1970 (present law) ¹	1970 (proposed) ²	1971 (proposed) ³	1972 (proposed) ⁴
Single.....	\$1,920	\$2,880	\$2,950	\$2,990
Worker with spouse.....	2,880	4,320	4,426	4,488

¹ Social security benefit for worker retiring at national average manufacturing. Wage \$6,990 estimated.

² Benefit for worker retiring with proposed 50-percent increase, with \$100 minimum.

³ Benefit for worker retiring with proposed 50-percent increase, with \$110 minimum. Average manufacturing wage estimated, \$7,330.

⁴ Benefit for worker retiring with proposed 50-percent increase, with \$120 minimum. Average manufacturing wage estimated, \$7,770.

Note: This is for worker at average earnings in manufacturing industry retiring end of year indicated.

Our Social Security system is uniquely suited to making such goals attainable. We have no other comparable social institution that has near universal coverage, safety of benefits, portability of credits and rapid vesting. Social Security alone can translate socially arrived at basic standards of retirement security into effective national policy.

We are failing to achieve optimum use of this great institution. We can use it as a tool to guarantee American workers the opportunity for a decent and dignified life in retirement. We are not, when the average benefit for a retired worker is below the poverty level and the benefits to a couple hover around the poverty mark. We are not using our opportunity to improve the quality of life in America if we pretend that periodic revisions of the existing benefit structure to compensate for past increases in living costs are all that is needed.

The new benefits we are proposing are so modest as to leave a substantial role for supplementation through private pension programs. It has been estimated, however, that while about a third of the work force covered by OASDHI is also building up credits under private pensions, somewhat less than 20 percent of the current aged is receiving private pension benefits. We anticipate some continued improvement in both coverage and benefits under private plans, but undue optimism would be unwise. One paper included in a 1967 compendium on Old Age Income Assurance for the Joint Economic Committee of Congress made the following warning:

"Over the next dozen years, the proportion of the aged with dual protection—from both OASDHI and private pensions—might rise to 25 or 30 percent, compared with 18 percent today. There is no real likelihood in the foreseeable future, however, that a majority of older people will become eligible for supplemental pensions. Too much of the problem of income maintenance for old age is a problem of survivors' insurance for widows which is seldom covered by private pension plans; too many jobs are difficult to include in private pension plans; and very early vesting would be required to supply protection to the large number of workers that change jobs frequently."⁵

⁵ Elizabeth M. Heidbreder, Walter W. Kolodrubetz, and Alfred M. Skolnik, "Old Age Income Programs" in *Old Age Income Assurance, Part II: The Aged Population and Retirement Income Programs*, a Compendium of Papers on Problems and Policy Issues in the Public and Private Pension System. Joint Economic Committee, 90th Congress, 1st Session, December 1967, p. 93.

We must continue to look to the public program to meet universal and basic needs in retirement, while the private system acts in complementary fashion to meet special needs of individuals and specific groups in our economy. But it seems clear that the basic economic mainstay of American workers in retirement will remain the Social Security system.

C. We recommend raising the base of covered earnings to not less than \$15,000 by a series of increments over the next several years. Provision should also be included to require Congress to act to make subsequent adjustments in keeping with changes in the levels of wages in the economy.

Any serious review of the Social Security system looking towards improvement and reform must consider carefully the question of an appropriate base for contributions and the top limit of covered earnings. The size of the base bears importantly on the volume of revenue that will be generated by the contribution rates, on questions of equity among beneficiaries and among contributors and on the extent to which the program retains an earnings-related character.

It is no exaggeration to suggest that many of the shortcomings and problems in the system stem from a failure to maintain the base at an appropriately high level. In consequence we pay for this failure in:

(a) Benefits that bear no practical relationship to preretirement earnings for workers whose earnings regularly exceed the base;

(b) Lower benefits for long-time retirees, whose earnings regularly exceeded the base, than those payable to more recent retirees whose actual earnings were no higher;

(c) Higher contribution rates than would be required to maintain the actuarial balance of the trust funds if virtually all earnings were taxed, and

(d) An intensification of the regressive nature of the payroll tax so that those with earnings below the maximum pay at a higher percentage of total earnings than those with earnings above.

The Administration has recognized the need for some increase in the amount of the base by suggesting it be raised to \$9000 in 1972 and pegging it thereafter to changes in wages. The \$9000 figure is justified on the basis of producing "approximately the same relationship between the base and general earnings levels as that of the early 1950's." Others have suggested \$10,000.

I do not believe that either is good enough. Social Security was suffering from essentially the same deficiencies in the 1950's that are currently interfering with a desirable level of performance. Why would it not be desirable to return and maintain something close to the relationship that existed at the time of the original 1935 Social Security Act? The then current base of \$3000 was at a point where 95% of earnings in covered employment were subject to the tax and counted for benefit purposes. The full earnings of 98% of all covered workers were included. A figure substantially in excess of \$15,000 would be required now to restore the same relationship.

From 1935 to 1950, however, there was continual erosion. Partial restoration was made in 1950 and on several occasions since then, but at no time was the 1935 relationship restored. Currently, it is doubtful whether the present \$7800 figure covers the wages of as many as two-thirds of all regularly employed males.

Our goal now should be to establish a base that will begin to approach a restoration of the 1935 relationship and to maintain that relationship as earnings levels increase.

D. We recommend protecting the purchasing power and living standards of retirees by:

(1) *Mandatory periodic benefit adjustments to reflect changes in the cost of living.*

(2) *Similar mandatory periodic benefit adjustments to provide an improvement factor comparable with the increases in real wages for those still in the work force.*

One of the most difficult challenges facing us in attempting to reform Social Security is how to achieve decency, equity and a share in the future for persons already on the retirement rolls. The problem would be more readily manageable if the life span in retirement were short. But advances in science and technology are lengthening the life span, permitting more people to reach retirement and making possible a shortening of the working life. The challenge was posed in the recent task force paper presented to the Senate Committee on Aging as follows:

"II. More Americans are spending more years in retirement periods of indeterminate length and uncertain needs, causing a mounting strain on resources they had when they began retirement. For an ever-rising proportion of women—most of them widows—the problem is especially severe.

"Half of all people now 65 and over are about 73 or older. In the years ahead, the increase will be particularly great at the oldest ages. With the population 65 and older projected to rise 50 percent between 1960-85, the population 85 and older may double.

"Increasingly, the rising population of widows is attempting to live independently, even if independence is purchased at the price of poverty.

"Our 'retirement revolution' reflects two trends; at one end an increase in the number of very old aged; at the other, earlier departure from the labor force."⁶

I believe it is generally accurate to state that we have chosen to avoid dealing with this challenge in any fundamental way. It is true that in some of the Social Security legislation of the early 1950's Congress did provide for differential increases among beneficiaries at various benefit levels. For the most part, however, increases have been based on uniform percentages for very nearly all beneficiaries.

What this means in dollars and cents is that the benefits of persons long on the rolls—far from generous when they began retirement—are simply less than those more recently awarded benefits. Thus the average retirement benefit paid in fiscal 1969 was \$99.69 while new benefit awards averaged \$105.19. Stated another way: a worker who retired in 1955 at age 65, who was entitled to the then maximum monthly benefit of \$98.50, now receives \$127.10. A worker who retired at 65 in 1965, having made maximum contributions from 1951, was initially entitled to \$132.70; now he receives \$150. A uniform percentage increase is undeniably helpful to both workers, but it also widens the differential between them.

Increases in Social Security benefits since 1950 have, at best, no more than matched increases in living costs. Actually, the performance has not been even that good, because the benefit increases usually come long after the fact of price increases. This is graphically illustrated for 1954 retirees on the attached chart taken from the Task Force paper to the Senate Committee on Aging.

In the same interval, however, wages have increased considerably. This average weekly earnings in manufacturing employment increased from \$58.32 in 1950 to \$122.51 in 1968. If these figures are adjusted for price changes, the 1950 figure becomes \$84.40 in 1968 prices. Thus real wages over this period increased by 45 percent while there were no commensurate changes in the real value or benefits payable to those retired from the work force. While there has been marked improvement in the general standard of living, retirees have not shared in it.

Proposals that would automatically adjust benefits, beginning in 1971, to future price changes alone, are not the answer. They will serve only to freeze into the program its present inadequacies and limitations.

What we must do is design a program that includes an adequate benefit structure, reasonably related to minimal, average and higher than average earnings, and a wage base for contributions and covered earnings suitable for a growing economy, that will protect the benefits of workers once they retire, not only against benefit erosion caused by rising consumer prices, but also to reflect changes in wage levels and improvements in living standards occurring after their retirement.

⁶ "Economics of Aging: Toward a Full Share of Abundance, a Working Paper," U.S. Senate, Special Committee on Aging, 91st Congress, 1st Session, pps. VII and VIII (emphasis in original).

RISING PRICES OUTDISTANCE SOCIAL SECURITY BENEFITS

FROM:
 ECONOMICS OF AGING:
 TOWARD A FULL SHARE IN ABUNDANCE
 A Working Paper
 Prepared by a Task Force - for the
 SPECIAL COMMITTEE ON AGING
 UNITED STATES SENATE
 March 1969

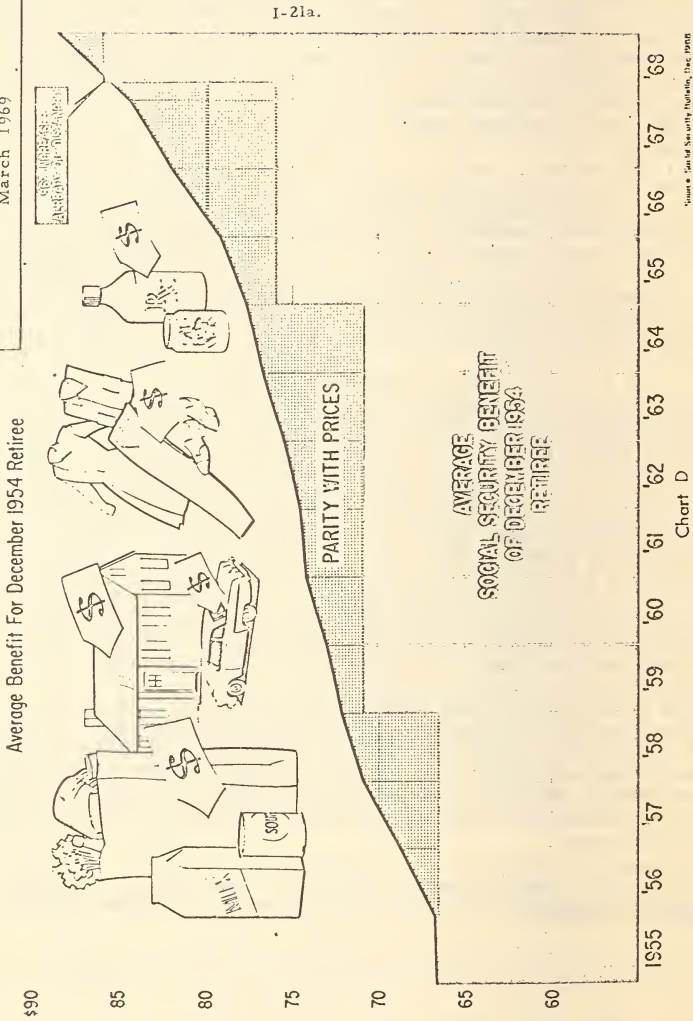


FIGURE 18A

E. We recommend immediate contributions from general revenues of the Federal Government to assist in financing the Social Security program. Initially such contributions may need to start on a relatively small scale. They should, however, now be scheduled to increase by steps until workers, employers and the Federal Government each bear about one-third of the total costs.

Not far reaching, basic reform of Social Security is practicable or equitably attainable if it does not also include a new method for financing. It is imperative that Congress resolve now to begin to rely on general revenues to meet the needs of the system. Reforms of the kind required demand new revenues to the trust funds in larger amounts than can be made available from the existing actuarial surplus and the Administration's proposed increase in the earnings base.

General revenues are now contributing to the cost of Medicare Part B and the special benefits payable to certain persons over age 72, but Congress has been reluctant to finance any part of the retirement, disability, survivor and hospital insurance programs in that manner. I believe the need for significant general revenue financing now is inescapable:

(a) Existing payroll taxes are regressive and already place an unjustifiable burden on the working poor. It is inconsistent with the expressed objectives of tax reform and proposed income guarantees not to include some relief from the burden of payroll taxes, *without loss of benefit rights*, for low income families. Still higher payroll taxes would not only be disastrous for these persons but would intensify the regressive impact of the tax on middle income families with more than one wage earner. Further to impose heavier payroll taxes rather than to introduce general revenues raises anew the divisive question of undue tax burdens on younger workers to pay for new benefits for those already retired or about to do so.

(b) The Social Security system is above all a program of *social* insurance. By every criterion of equity and justice the major improvements needed now to improve the situation of the millions of recipients living in poverty or near poverty represent a *social cost* that should be shared by all tax-payers,

(c) While I am unwilling to hazard a guess on what might constitute an acceptable upper limit for the payroll tax rate, the history of Social Security legislation in the United States convinces me, on purely practical grounds, that it is extremely unlikely that we can achieve decent levels of Social Security benefits as long as we continue to rely almost exclusively on the payroll tax.

(d) More adequate Social Security benefits made possible by general revenue financing will reduce sharply the numbers on public assistance rolls, particularly among those receiving Old Age Assistance and Aid to Families with Dependent Children. By providing an alternative to public assistance under a means test, many will become self-supporting. These savings would reduce the net cost of the new funds required from general revenue contributions.

(e) The concept of general revenue contributions for adequate financing of social insurance is neither radical nor new. It has been recommended on previous occasions by thoughtful and informed individuals and by competent and responsible public advisory groups. President Roosevelt's Cabinet Committee on Economic Security, in drawing up the blueprint for the original Social Security Act, clearly foresaw the eventual need for contributions from general revenues in order to assure that "workers who are now middle-aged or older and who therefore cannot in the few remaining years of their industrial life accumulate a substantial pension reserve be, nevertheless, paid reasonably adequate annuities upon retirement." In 1966, the "Report of the Advisory Council on Public Welfare" also called for a substantial general revenue contribution. In addition, a number of the Social Security advisory councils recommended general revenue support, and during the 1940's, Congress actually authorized general revenue appropriations, although none were made and the authorization was repealed in 1950.

(f) Persons opposing general revenue financing argue that Congress might shirk its responsibility by failing to make the necessary appropriations from general revenues and that a government contribution will undermine the wage related character of the system. Our own experience, and that of the bulk of the industrialized free nations of the world should persuade us that these fears are groundless. I refuse to believe that Congress would choose to behave in such irresponsible fashion. The truth is also that within a context

of maintaining an earnings related structure, many beneficiaries have received greater amounts than would be justified on the basis of what they "earned" alone. General revenue financing has not brought ruin to other nations regularly contributing from general revenues to Social Security programs including such nations as Australia, Austria, Belgium, Canada, Chile, Costa Rica, Denmark, Federal German Republic, Iceland, Ireland, Israel, Italy, Japan, Mexico, Netherlands, New Zealand, Norway, Philippines, Sweden, Switzerland and United Kingdom.

The demands of our other commitments at home and abroad do not preclude adequate support for Social Security now. On the contrary, I am convinced that our fiscal capacity permits, and our national goals demand, far-reaching reform and improvements of the system.

Support of our men in Vietnam, of programs to ease the problems of our cities and of the space program, should not require neglect of our elderly. Nor should the young adults of America, just beginning to raise their families and struggling to achieve economic security, be saddled with unnecessary and burdensome taxes upon their pay, when general revenue can readily be used to finance increases in the Social Security benefits.

We must finally recognize that there is no practical and conceivable level of payroll taxes that will fully and equitably pay for a Social Security system that deals generously with those whose earnings have been lowest and that provides decent, adequate benefits for those who have more than minimum earnings. This is an issue that will not fade away, unless Congress now assumes the leadership and faces it squarely.

While the minimum, the overall benefit structure and the financing determine the basic shape of the OASDI system, I cannot leave the subject of the income benefits without advancing several additional proposals and commenting briefly on various aspects of current proposals.

F. We recommend paying aged widows 100 percent of the primary amount that would have been paid at age 65 to their husbands.

It is doubtful whether there is any class of beneficiaries for whom benefits are less adequate than for aged widows and widowers. At the end of 1968, more than half of them (53.2 percent) were receiving less than \$90.00 monthly, and almost two-thirds, 63.3 percent less than \$100.00.⁷ In logic, or on any basis other than as a device for holding down costs, there is no magic in pegging their benefits at 82½% of the amount that was or would have been payable to their husbands on retirement. Without minimizing the obvious public interest in maintaining a proper relationship between income and outgo of the trust funds and in continuing an appropriate balance among the various beneficiary classes, I believe the circumstances of aged widows justify giving them a greater equity in the Social Security system.

We are pleased that the President also recognizes the seriousness of the problem and to join him in asking for your approval of his recommendation.

G. We recommend that male retirees be given equal treatment with women in being able to exclude retirement years after age 62 from the five permissible "drop out years" used in computing their average Social Security earnings. We further recommend that in any case benefits be computed on the basis of the worker's highest ten years of earnings.

We are concerned with the low benefit amounts payable to the large, and increasing, numbers of workers and their spouses who elect the permanently reduced, early retirement benefits available starting at age 62.

Unfortunately, our public retirement system, unlike private pension plans, is unable to distinguish between those who choose voluntarily to retire and those who are displaced and forced prematurely to retire.

Under the present law, the "drop out" provisions affecting computation of average earnings in combination with the actuarial reduction for retirement before age 65 may levy an unjustifiable additional toll on the benefits of workers least able to afford it. Those most affected include workers who are forced into early retirement by technological change, plant closings or because of inability to sustain the exacting pace of many kinds of industrial employment. If these workers happen also to have had gaps or reductions in earning in prior years caused by illness, layoffs, short weeks or shifts to lower paid jobs, they lose much of the benefit of the "drop out".

⁷ Information furnished by Social Security Administration from a compilation of State and county OASDI statistics.

These are the persons who reach retirement with low average earnings and qualify for low benefits—much lower than would be caused by the actuarial reduction alone. They are required to use their allowable “drop out” years to exclude periods of sickness or unemployment and have to retain for benefit computation purposes years with a low taxable wage base. In addition, if they are male, they gain little from the “drop out” because they must count the years between retirement and age 65.

Wherever I go, I have occasion to meet workers in their fifties and early sixties whose skills have become obsolete, who have lost their jobs when a plant was moved, or was closed in a corporate merger or whose job is performed by an automated machine.

I believe we owe it to these people to assist them to upgrade and update their skills so that if they are able to, they continue to be productively employed.

For anyone who cannot find suitable employment, equity demands steps to protect the benefit rights he earned while his skills and labor could command a wage in the job market.

We have noted that the President is also asking Congress to permit male workers to retire at age 62 without the penalty on their benefits of counting the period from age 62 to 65 as years of no earnings. We believe this is a constructive proposal that merits your support, but we also believe that the additional measure we suggest is required to recognize the developing trend toward earlier retirement and to relate more closely benefits to pre-retirement earnings.

H. We recommend that the Congress pass legislation establishing private pension plan reinsurance.

These plans play an essential complementary role to the Social Security system.

Business failures, plant shut-downs and other factors arising from technological change and competitive forces have resulted in the unforeseen and often abrupt termination of an otherwise sound pension plan at a time when currently accrued assets are insufficient to meet accrued benefit liabilities. Such pension plan terminations all too frequently subject affected workers to the double tragedy of lost jobs and loss of substantial prospective pension rights at a stage in life when they have little or no opportunity to earn further benefit entitlements.

I. Other proposed changes

Finally with respect to other Social Security income benefits, let me urge you to take favorable action on the President's specific recommendations to:

(a) Provide non-contributory earnings credits for military service from January 1957 to December 1967.

(b) Pay benefits to dependent parents of retired and disabled workers.

(c) Extend to 22 the age at which a child may qualify for a benefit on the basis of becoming disabled, and

(d) Pay full benefits to persons in the year they attain age 72 without regard to their earnings in that year.

I have chosen deliberately not to comment at length on the proposals to liberalize the existing retirement test. These proposals have wide support. I know too that the retirement test needs updating and that the range of dollar for dollar benefit reductions creates anomalies because each dollar reduction may mean a net income loss of more than a dollar. I must point out, however, that liberalizing the earnings test is not the basic answer to the problems of our older population of which 80 percent is, in fact, retired. No liberalization of the earnings test will help those who are already retired, but their needs and their equities cry out for relief.

J. Reconsidering certain recent amendments

I believe further that some of the provisions included in the Social Security Amendments of 1967 were undesirable and merit re-examination. Specifically, we favor legislation that would:

(a) Eliminate age 50 as the minimum qualifying age for benefits for disabled widows and widowers and pay full benefits (without actuarial reduction) at any age to qualified persons on the basis of the primary insurance amount that would be payable at age 62.

(b) Permit payment of a wife's or husband's insurance benefit on the basis of a full 50 percent of the worker's benefit with no ceiling.

(c) Apply the same definition of disability to widows and widowers as to disabled workers, and

(d) Drop inappropriate geographical considerations from the tests for determining a worker's disability.

For the most affluent nation in human history, a nation whose gross national product is rapidly approaching a trillion dollars, our proposals concerning the cash income benefits are more than temperate when compared to needs. They are not beyond the minimum improvements justified by today's economic circumstances. They are in no way radical, and are novel only in that they represent a break with the practice of periodically doling out minute benefit increases and tinkering with this or that inequity without acknowledging how pitifully small the benefits are in comparison to the debt we owe those receiving them.

Far reaching as those recommendations may seem, they still do not provide the measure of security and dignity to which an American worker is entitled after a lifetime of work. We will not have achieved an effective and adequate social insurance system until the OASDHI program can assure that workers can look forward to Social Security retirement incomes of at least two-thirds of average annual wages before retirement, with subsequent adjustments to follow wage, price and living standard changes.

There is no cheap or painless way to meet our responsibilities. This is no time to avoid them.

I urge you to judge critically all of the proposals you have seen, for you still have the opportunity to move forward to meet the social needs of our times. I urge you to use that opportunity.

II. HEALTH CARE PROGRAMS

No more than casual observation is needed to realize that this is a crisis era. Housing, cities, natural environment, education and race relations are all in crisis. The Alliance for Labor Action recognizes an urgent need for massive national action to overcome pressing problems in these and related areas.

Today, however, our nation faces no greater crisis than that which is now so apparent in health care. Here, failure to act, literally has been fatal.

President Nixon has recognized our nation's health care crisis. At a press conference this summer, he stated:

"We face a massive crisis in this area (health care) and unless action is taken both administratively and legislatively to meet that crisis within the next two or three years, we will have a breakdown in our medical care system which would have consequences affecting millions of people throughout the country."

President Nixon's statement understates the urgency of America's current health care needs. There is now evident a growing public awareness of the new potentials and opportunities that our progress in science and technology can offer, but we are held back by archaic and outmoded social organizations. For all of America's recognized superiority in medical science and technology, we are failing to make optimum use of health resources because:

1. *The cost of health care is sky-rocketing.*—It represents the single most inflationary factor in the upward movement of the price index. The cost of medical care over the past decade has risen at almost twice the rate of the movement of the general price index. If we are going to fight inflation, as we must, we have to look at the increasing cost of health care and realistically begin to deal with the sources of the problem.

2. *We spend more money in total and a larger percentage of our Gross National Product (6.7%) for health care than any other nation in the world.*—Yet despite this, unlike many less affluent nations, we have not provided the American people with the kind of comprehensive high-quality health care services that we have the knowledge and the resources to provide.

3. *We are not getting the maximum yield from our expenditures because we lack effective organization for the delivery of health care services.*—Ours is a non-system.

4. *In no industrialized nation in the world is the gap between the "have" and the "have-not" people, in their respective ability to gain access to adequate health care, as wide as in the U.S.*—America's health care crisis is being perpetuated by our disorganized, obsolete and inadequately financed health care program. Health care in America has too long been wasteful of its valuable human and technological resources. Unrealistic and irrational divisions between public and private responsibilities and methods of financing and delivery of service have furthered the crisis we must now face. *This matter is of such crucial importance at this time and in the years immediately ahead that I urge the House Ways and Means Committee to plan a series of hearings specifically geared to bringing together various viewpoints and bringing to light the best of current knowledge regarding desirable approaches to structuring and financing a comprehensive, nationwide, national health insurance program.*

A. *The inadequacy of our health care non-system*

1. *Ill health and the current "system."*—An important measure of the inadequacy of our health care "non-system" is its inability to deal with health problems. The failure to deal adequately with urgent health care problems can be traced in part to shortages and maldistribution of health care personnel and facilities, seriously compounded by the misuse of these scarce and valuable resources. As a result of this failure, appalling statistics confirm the extent of our national health care crisis.

The U.S. death rate over the past twenty years has remained relatively stable at around 9.5 per 1,000 of population per year. The death rates from heart disease and cancer, leading causes of death, are both increasing. The United States is, today, no better than fourteenth among the industrial nations of the world in infant mortality, compared to eighth in 1953.

The impact of limited access to quality health care is particularly evident in maternal and infant health. In some areas of Detroit, for example, the rate of infant mortality is as high as 69.1 deaths per 1,000 births, more than two-and-a-half times the United States' national average. In other parts of Detroit, the infant mortality rate is 12.1 per 1,000, about half the national average. In Detroit's "inner city", maternal deaths occur almost seven times as often as in Michigan, or the nation, as a whole.

Other mortality data confirm the observation that our health care services have been similarly deficient at other stages of the life cycle.

In terms of life expectancy at birth, the U.S. ranks no better than 26th for males and 12th for females, among the nations of the world.

The U.S. death rate for males in their most productive years (40–50 years old) is at least 20% higher than the rate in a dozen other countries, including Canada.

2. *Neglect of the poor.*—Today, not even the affluent consistently receive a level of health care as good as our nation is capable of providing. In our health care "non-system," with its outmoded double standard of delivery for the "haves" and "have nots", however, the poor inevitably fare worse.

Health care has failed most obviously when the need has been greatest. In a report of the National Center for Health Statistics, the high incidence of illness among the poor was recently summarized. As compared with higher income people in the U.S., the poor have:

"Four times as many heart conditions . . . ; six times as much mental and nervous trouble; six times as much arthritis and rheumatism; six times as many cases of high blood pressure; over three times as many orthopedic impairments; . . . and almost eight times as many visual impairments."

These facts are shocking and frightening. The poverty-poor health cycle literally drains the poor and denies them and the nation of their full potential. The nation's poor have insufficient access to good medical care and practically none to preventive services.

Medicaid and special programs to upgrade health services to poverty groups are proving totally incapable of meeting the real and pressing needs of the disadvantaged poor. Medicaid expenditures have skyrocketed because of unjustified inflation and some flagrant abuses by providers of service. In testimony by the UAW and other labor groups, more will be said about reforming Medicaid. It is safe to say, however, that virtually nothing meaningful is being done presently to improve the level and quality of service available to a vast majority of the poor even though ways of reaching low income groups have been developed and tested. Here, too, we have failed to realize, by a substantial margin, the health care potential of which our nation is technically and financially capable.

3. *Disorganization in health services today.*—The consumer is faced with a bewildering range and complexity in the services he is seeking in order to meet his rapidly changing needs both for "care" and for "cure". He is faced by a nation and a community that lack an understandable and accessible organized system of health care services.

A general characterization of today's health services would have to recognize the following:

(i) A wide variety of institutional facilities and services, highly uneven in scope and in quality of performance;

(ii) private practitioners, groups of practitioners and clinic facilities, varying greatly in their ability to meet the *total* health needs of patients; and

(iii) a bewildering overlay of often inefficient, costly and usually uncoordinated programs and methods to finance and deliver services.

In brief, our health system lacks coherence, comprehensiveness and sound organization.

In a nation which prides itself on the most modern technological and organizational development of industrial enterprises, our primary health care problem arises from our archaic methods of organization for the delivery of health care.

Consider the two most significant components of health services, hospital care and physicians' services. Our hospitals are experiencing:

- (i) A fantastic pattern of rising costs;
- (ii) both over-utilization and under-utilization of existing hospital resources;
- (iii) unnecessary duplication of services and facilities;
- (iv) inappropriate use of acute general hospital beds for chronic and convalescent cases;
- (v) the effect of limitations of insurance coverage which put incentives on hospital admissions;
- (vi) faulty relationships between hospitals and their medical staffs;
- (vii) misuse of highly trained staff;
- (viii) failure to apply effective and economical management techniques not inconsistent with a high quality of care.

Despite the alleged advantages of competition within the American medical system, our physician services are characterized by:

- (i) Maldistribution;
- (ii) over-specialization;
- (iii) fragmentation of care;
- (iv) highly uneven quality of performance;
- (v) delivery systems which do not achieve efficiency and economy in the use of medical skills;
- (vi) serious deficiencies and inequities in the "price control" system operated by the profession.

The nation's inadequacies in dental care, various institutional services, the provision of drugs, eyeglasses and other health services and products, also reflect the growing disparities arising out of our continuing inability to grasp the crucial concept that modern health services cannot be assured through the "medical marketplace", but require effective organization and financing in order to reach their full potential.

The present lack of a national health policy and a national health insurance program is now widening the gap between the high potential and the actual performance of our health institutions and professionals. Without meaningful planning under a system of national health insurance, disorganization of services, ineffective performance, and continued inflationary pressures will further erode the value of our nation's increased spending on health care.

4. *Failure of private insurance.*—Over the past thirty years, private health insurers have made a constructive contribution to the financing of medical services in this country. However, even after such a major effort, we know that:

- (i) Hospital expenses are most frequently covered under health insurance. Still, about 25 million people, almost 15% of those under age 65 years, *have* no hospital insurance whatsoever. Many others have only partial coverage for hospital expenses.
- (ii) As of January 1, 1968, of the 178 million Americans under age 65:
 - (a) 35 million people—20%—had no surgical insurance;
 - (b) 89 million people—50%—had no insurance to cover x-ray and laboratory examinations when not in the hospital;
 - (c) 102 million people—57%—had no insurance to pay even partly for visits to doctors' offices or doctor visits to their homes;
 - (d) 173 million people—97%—had no dental insurance; and
 - (e) 108 million people—61%—had no insurance protection whatever against the cost of prescribed drugs.

In addition to the evidence of the limited scope of coverage for large proportions of the population, particularly for out-of-hospital services, our "non-system" fails in an equally significant test of performance, the extent of economic protection that private insurance affords the total population.

Medicare's protection has, to a large extent, reduced the need of the aged for coverage of hospital and physicians' services through private health insurance. Medicaid, despite its glaring inadequacies, has financed much needed health care for a large segment of the indigent population. Private insurers have had serious difficulty in reaching both groups. But even after setting aside the now very substantial government payments for personal health services for the aged and

indigent, private health insurance still is only meeting approximately a third of the residual private consumer health bill. And this gross figure, of course, minimizes the fact that insurance protection varies widely among different segments of the population.

In addition to its inability to provide adequate protection over the total population, private insurance:

- Has serious limitations and deficiencies in the range of health services brought under insurance;

- Has not dealt adequately with questions of quality and appropriateness of services nor prevented abuses by providers and recipients of services; and

- Has organizational weaknesses and a private institutional character (replete with "conflict of interest" issues) which limit its ability to serve as a major instrument of public policy.

To be more explicit, private insurance:

- Has concentrated on general hospital care and surgery, while neglecting the most significant area of health care, namely, general and specialist services to non-hospitalized patients;

- Has encouraged the overuse of some high cost services, such as in-patient hospital services, to the neglect of more appropriate and less costly forms of service, such as nursing homes providing varying levels of care and home nursing care, which have not been adequately insured;

- Has failed to develop and support new methods of delivering health care services such as prepaid, comprehensive group practice arrangements;

- Does not foster important concepts of health care, such as prevention, early detection, rehabilitation, and above all, comprehensiveness and continuity of care.

The conceptual, structural and financial limitations and deficiencies of the private insurance system cannot be rectified by turning it over to public corporations or by its retention within some system of government-subsidized health insurance coverage operating through competing private carriers.

Such "remedies", be they federal grants or subsidies, tax credits or other mechanisms, cannot assure to all Americans access to high-quality care, over the entire range of health services, within a system designed and operated to meet health needs and to make the most effective and economical use of our health care resources. We would simply be pouring more money into an out-moded program in a way which could only further inflate health care costs and would still fail to meet our essential health care problems.

Only a national health insurance system can reorganize health services and remove financial and non-financial barriers which now limit the individual's access to high-quality care and the ability of health institutions and professions to deliver it.

B. National health insurance

I believe that in no area of our national life is there a greater or more dangerous gap between promise and performance, between our goals and our record of translating our competence and capability into practical performance, than is apparent in the field of health care services. One of our problems in America is that too often we rely on the marketplace to find answers to basic social problems. The marketplace in America has been instrumental in providing us with great national wealth. But the marketplace is incapable of responding adequately to provide many basic human and social needs and services, such as health care services. The dimensions of the problem are so immense that it is beyond the capability of the private health sector in America to provide a solution.

The labor movement in America has long been aware of the need for, and responsibility of, all major elements in our society to define and promulgate a variety of social goals and priorities, so as to provide the public and its leaders with soundly developed guidelines and choices for furthering programs directed to human betterment and the strengthening of our democratic ideals.

The Alliance for Labor Action is convinced that our nation requires a nationwide program of health insurance to marshal and expand our health resources and to provide a reliable and equitable financial base needed to assure the delivery of the full range of preventive, curative and rehabilitative health services to all Americans.

Some may argue that the costs of such a national system are beyond our capacity as a nation. This argument cannot be taken seriously in the richest nation on earth—a nation which already spends a higher percent of gross national product on health services than any other. On the contrary, the rapidly

rising costs of health services require that we redistribute our expenditures through an organized health care system if the value of our current spending is not to be further eroded by inflation and inefficiency. Indeed, such an organized system must not only better rechannel the current costs of health care, but must also assure the financial commitments necessary to upgrade the current level of performance of our health care system.

As you are no doubt well aware, the Committee of 100 for National Health Insurance (CNHI) has already begun work on proposals for far reaching reform of our nation's health care system and its financing. The Committee includes outstanding Americans from all walks of life and has strong support from labor and other consumers of health care as well as from many of the providers of health care. (In fact, more doctors are members of the Committee than any other occupational group). I have the privilege of serving as Chairman of the Committee.

CNHI fully recognizes America's health care crisis. It is dedicated, therefore, to the development of a national health insurance program that will stimulate the provision of comprehensive high-quality health care for every American. CNHI will, early in the new year, make available to Congress and the nation a specific proposal for a national health insurance plan based on our Social Security system.

The demand for national health insurance is steadily gaining ground. The national Governors' Conference strongly endorsed the concept and several bills in this area are presently before Congress. Surely the House Ways and Means Committee, as part of its study of the Social Security system, must include a thorough consideration and evaluation of a comprehensive approach to meeting our deepening crisis in health care *by an extension of the Social Security system*. Such a study must include an explicit examination of the essential objectives and criteria which should guide a new national health insurance program.

In the view of the Alliance for Labor Action, the essential objective of a national policy becomes clear, once it is realized that America can no longer continue to patch-up and perpetuate our disorganized health care system. *The objective must be to provide equal and actual opportunity of access of all persons to a comprehensive range of high quality health services, without avoidable limitations dictated by geographical boundaries, variations in state or local resources or the economic or health status of the individual.*

A system designed to meet this objective must be judged on the following major criteria:

(i) *Universality of coverage.*—The degree to which residents are covered as a matter of right.

(ii) *Comprehensiveness of benefits.*—The extent to which the program includes the entire range of services necessary for the maintenance of personal health, for the early detection of disease, for care and treatment of illness and for rehabilitation, when needed.

(iii) *Acceptable and economical payment mechanisms.*—The effectiveness of the methods chosen to remunerate providers of services in assuring full financial protection to the public and fair and acceptable payments to the providers.

(iv) *Support for new delivery systems.*—The means of achieving economy and effectiveness by the use of evolving new forms of group organization of service, personnel and facilities.

(v) *Positive quality and performance standards.*—The provisions available to safeguard quantity, quality, effectiveness, continuity and economy of services.

(vi) *Means to accelerate the development of needed health manpower and facilities.*

(vii) *Equity and adequacy of financing.*—The extent to which the program has a reliable and adequate source of funds, consistent with ability to pay principles, required to provide both the developmental and operational costs of the program and to assure its continuing improvement.

(viii) *Capability and effectiveness of administration.*—How well it develops an administrative system sufficiently broad in scope to meet the national objectives of the program.

(ix) *Public control of basic policies.*—The extent to which the system is accountable to public authority and responsive to consumer needs and objectives.

A system which satisfactorily meets these criteria would assure high-quality health care for all Americans at a price America can well afford.

Our nation has the opportunity to develop a new system of nationally insured, coordinate health care unlike any other in the world. The issue is not "socialized medicine", as opponents of reorganization would have you believe. We are not talking about the Government taking over the hospitals or doctors going to work for the Government. We certainly are not advocating borrowing or transferring the health insurance system of any other nation, because we believe that our problems and our capabilities are different. What we need to do is to develop a uniquely American system which will preserve the best features of our current means of delivering health services, while dealing with other basic organizational and financial deficiencies, to make possible the provision of comprehensive, high-quality, care, equitably and soundly financed, to all Americans.

There are those who are advancing the view that as a nation we are not ready to undertake a system of national health insurance until "we get our health care house in order". These well-meaning persons appear to miss the essential point—we will not be able to get our health care house in order until it is related to a comprehensive system of organization and financing of personal health services. I have attempted very briefly to indicate some of the key problems as well as the essential criteria by which any proposals for restructuring the nation's personal health services need to be evaluated. I urge upon the Committee the need for immediate serious and in-depth studies of the totality of the health system to which changes in Medicare, Medicaid and other health programs need to be related.

Mr. ULLMAN. You have, as usual, made a very stirring and a very articulate plea, Mr. Reuther.

Are there questions?

Mrs. Griffiths?

Mrs. GRIFFITHS. I would like to congratulate you, Mr. Reuther, on your statement, and I might say that I consider Blue Cross and Blue Shield is to the medical cost in this country roughly what the Pentagon is to the national budget. I noticed in your prepared statement that you have said something about the congressional pensions and you have quoted the Detroit News on page I-3. I would like to ask you under your present pension plans of the UAW what would a man receive in pension who had worked 32 years on the line at the date of retirement? What placement of wages would it amount to?

Mr. REUTHER. I think that a man with 32 years getting the average wage, say, in General Motors, which would mean he could be an assembler, would get something approximating \$2,250 a year.

Mrs. GRIFFITHS. And what percentage of wage replacement is that?

Mr. REUTHER. Apart from the amount of overtime earnings, which is always an important factor in the automotive industry, I think that would come pretty close to one-third of his wage.

Mrs. GRIFFITHS. How much did he pay in his working lifetime toward that pension?

Mr. REUTHER. Toward the privately negotiated pension?

Mrs. GRIFFITHS. Yes.

Mr. REUTHER. Well, we have in the automotive industry what is called a noncontributory plan. We do not delude ourselves. The worker really pays the full cost because contributions are a diversion of wages or of economic gains that he could get in some other form. I can't really give you a figure, although I can get our research people to pull that together and send it to you.

(The following was received by the committee:)

UAW,
DETROIT, MICH., November 20, 1969.

HON. MARTHA W. GRIFFITHS,
U. S. House of Representatives
House Office Building,
Washington, D.C.

DEAR MRS. GRIFFITHS: In response to a question you asked during my appearance on behalf of the Alliance for Labor Action before the Ways and Means Committee on November 12, 1969, may I take this opportunity to add, and have made a part of the record, further information regarding retirement benefits under UAW-negotiated pension plans.

You inquired specifically about the benefits of an auto worker who might retire at age 65 after 32 years of service. As a result of our 1967 negotiations with the automobile companies, there are now for the first time some variations in benefit amounts related to job classifications at the time of retirement. There are three benefit classes so constructed that the workers are divided among them in roughly equal proportions. The total benefit from the negotiated pension plan for an average worker retiring with 32 years' service, however, is now \$2,244 a year, about 30 percent of preretirement earnings.

Although the number retiring with 32 or more years' service represents a significant fraction of all retirements, we have found that the typical worker retires with somewhat shorter service, approximately 25 years. With that service, total annual pension benefits for a typical worker are \$1,761, about 23 percent of earnings.

I want to reiterate my belief that in a very real sense the workers pay for these benefits in our collective bargaining with employers. It is literally true, of course, that the money to pay for them comes from employer funds. But these funds cannot be regarded as net additions to other labor costs. Whenever we negotiate an economic agreement with an employer, we have a range of alternatives from which to choose including wages, holidays, vacations, pensions, insurance, shift premiums and a host of others. The more we choose to allocate to say, improved pensions, the less there is available for wages and other benefits. I am certain, therefore, that if we had no pension plan, our wages and/or other benefits would be substantially higher than they now are.

May I state again that I am in complete accord with the idea that public servants, elective and non-elective, are fully entitled to economic security and reasonable comfort in retirement. I have never believed that persons in public employment should be expected to subsidize the community—whether through artificially low pay levels or inadequate benefits—simply because they are paid from public funds. You may be sure that my point was not that the civil service retirement benefits are too high, but that Social Security benefits are far too low.

Sincerely yours,

WALTER P. REUTHER,
President, International Union, UAW.

Mrs. GRIFFITHS. But in actuality as far as the worker is concerned, it did not come from his wage. What did he pay in taxes on that pension as it went into the plan? Is it charged to him annually during his working years?

Mr. REUTHER. No, it is not.

Mrs. GRIFFITHS. No, he does not pay taxes?

Mr. REUTHER. That is right.

Mrs. GRIFFITHS. There are a few things that the Detroit News didn't mention and it didn't point out that in the first place the average term of service of a Congressman is something a little more than 4 years, so that very few Congressmen have ever drawn a pension. It didn't mention, also, that Congressmen, one, are paying taxes on the money they put into the plan at their highest level of earnings and, two, I am reliably informed by Mr. Dent of Pennsylvania, that there has never been a penny drawn by a Congressman that wasn't paid for by Congressmen.

The Federal Government hasn't, the American taxpayer hasn't paid one dime yet for a Congressman's pension.

Third, that very few people would ever get these magnificent pensions that they are talking about of \$34,000. They are not even payable until 1972, and you would have to have 32 years to get it and, believe me, very few Congressmen have 32 years.

I wish you would come out and that the Detroit News would have come out for a mandatory retirement age for Congressmen, something like 65. I wish we were even treated like Federal judges; the day you take the oath of office you get the salary the rest of your life and you don't pay a cent for any of it. It seems to me that it would make considerably more sense to have a mandatory retirement age and a pension than what we now have, and I must say that I don't regard it as good a pension as the autoworker has and it is entirely possible that what we need to do is to have some negotiators down here. We are really cheating ourselves.

I would like to thank you.

Mr. CONABLE. This sounds like a proposition, Mr. Chairman.

Mr. ULLMAN. Are there other questions?

Mr. Burke?

Mr. BURKE. I would like to make this observation. Being close to 60 years of age, Mrs. Griffiths, I hope that you are not going to hold to that 65-year retirement.

Mrs. GRIFFITHS. I am for it for you.

Mr. BURKE. I just wish to commend you, Mr. Reuther, for your statement and commend you for the activity that you have engaged in over the past many years. I think you have looked at the problem very realistically.

I have filed a bill that calls for a 50-percent increase in social security across the board and I feel that the method of collecting the taxes for social security is wrong because the social security law has been freighted down in many amendments. In Germany, I believe, and in Sweden, and in England, part of the cost of social security in those countries is borne from general revenue. I feel that the format for the collection of taxes for social security should be one-third by the employer, one-third by the employee, and one-third by the Federal Government. This will mean the elderly will be able to be granted an increase that will at least try to meet the needs that they are faced with today.

If you care to comment on that statement, I would appreciate it.

Mr. REUTHER. I want to say that we appreciate your point of view on this because this is a matter of the highest importance. I mean we can discuss the level of benefits, we can discuss the question of refinement of structures, and so forth, but the crux of our problem is that we really are placing the total burden of social security benefits, with very small exceptions, upon the payroll tax. So that when we say to a young worker who may be 25 or 30 years away from retirement age, "You have to pay now to support a social security improvement," we get resistance. It seems to us that it is unfair and it is impractical to place the whole burden on the payroll tax. We ought to move in stages as quickly as we can to the Federal Government picking up a third of the total cost, as you have suggested, with the employer and the employee sharing equally the balance. We think that that is a much sounder approach than the current one and, as I said in my statement, we are one of the few democratic industrial na-

tions in the world that has placed the total burden of social security upon a payroll tax.

Mr. BURKE. Thank you.

Mr. ULLMAN. Mr. Gilbert?

Mr. GILBERT. Thank you.

I would like to welcome Mr. Reuther, and I am particularly pleased to have his support of my social security bill.

You made a statement, Mr. Reuther, which I didn't quite understand when you were talking about the social security being geared to the cost of living, which I agree with, and is part of my bill, and then you went further on to make a statement about sharing in the technological advances of society or of industry.

Is that the statement that you made, Mr. Reuther?

Mr. REUTHER. Yes.

Mr. GILBERT. What did you mean by that? I don't quite understand what you mean.

Mr. REUTHER. I shall be glad to try to clarify that.

If you give a pensioner a cost of living adjustment, then in effect you maintain his current and relative position in terms of current living standards. With people living longer now—and they are going to continue to live longer—doing only that would freeze them at that level. Their current living standards would not deteriorate because they would have a cost of living adjustment. But the rest of society would be moving forward. As automation and the new tools of science and technology expand our gross national product, and while all other people would be enjoying improvements in their living standards, the retirees would be frozen at their old ones.

I think they, too, ought to share in the general improvement in the living standards, and, therefore, we ought to apply some sort of periodic improvement factor to their pensions.

First, we have to raise the basic minimum, and we need to protect that with a cost-of-living clause. Then if society over a period of years is able to raise its general living standards, why should the retirees be left behind while the rest of society moves forward? Why shouldn't they share in the general improvement in living standards? That is what I would call an improvement factor.

Mr. GILBERT. I agree with your statement. It was just the wording of it that I didn't quite understand. In other words, what you are really saying is it should go beyond merely a cost-of-living factor and that the retiree should share in the increase in the gross national product?

Mr. REUTHER. Exactly. As the real wage position of the average American improves, that improvement should be reflected in the relative standard of living of retired people.

Mr. GILBERT. I agree with you completely there, Mr. Reuther.

One other thing. You were quoting statistics from the—was it the World Health Organization? That men in the United States rank 26 and women 12?

Mr. REUTHER. That is right. The latest report of the World Health Organization, which is an agency of the United Nations, shows that, among the nations of the world, in 25 other countries a man has a greater chance of living longer than in the United States. We are 26th for men, 12th for women, and 14th in the rate of infant mortality.

Mr. GILBERT. Is that because you think men work so hard in the

United States, harder, than women, with all due respect to Mrs. Griffiths?

Mr. REUTHER. I think it just proves that the women are made of sterner stuff.

Mr. GILBERT. I am inclined to agree with you.

Thank you very much.

Mr. REUTHER. Which I have known for a long time.

Mr. GILBERT. I am glad you said it.

Mr. ULLMAN. Mr. Corman?

Mr. CORMAN. Thank you, Mr. Chairman.

Mr. Reuther, I very much appreciate your statement. It would seem to me that one of the things you highlighted was our success in getting to the moon within the time schedule that we set for ourselves nearly a decade ago. I remember that we adopted a very realistic budget for that effort and we gave the administrators of that program almost exactly what they said they needed.

My worry about the welfare portion of this bill is not the laudable goal of providing training and child-care centers and minimum living standards for people. These are goals which we ought to attain. My worry is that we cannot do it unless we are realistic about how much money it will cost and then be willing to spend the money to do it. I am wondering if you could give us either now or for the record how much money we would have to invest if we raised all of the people in this Nation who are unable to work to the poverty level as defined by the Labor Department; if we provided adequate child-care centers for all of the children of the one-parent families who are employable; and, if we give realistic training to those who are employable once they have skills. It seems to be awfully important at this juncture that we look at how much it is going to cost.

My fear is that we will set ourselves these goals and we will underfinance it miserably and then blame the poor because they have failed.

Mr. REUTHER. I can't give you offhand a budget or cost projection for doing the things that you referred to. I do believe that the social security recommendations we made are within the fiscal capability of the present structure, if the base is raised to the \$15,000 figure we suggest and if Congress begins to make use of general revenue resources. Our proposals have been studied and been found fiscally possible by the actuaries of the Social Security Administration.

With respect to the broad question that you have touched upon which gets into training and poverty, welfare, day care, and the like, I think that we have to recognize that America has never fully realized its economic potential in peacetime.

In 1946 the Congress of the United States adopted the Employment Act of that year which committed us as a matter of national policy to achieve maximum levels of employment, maximum levels of production, and maximum levels of purchasing power.

We have achieved none of those three goals.

We have wasted 53 million man-years of potential production during those 22 years. But if we had used our manpower, if we had gotten out of the American economy its maximum economic potential, we could have increased our gross national product over that period by what our economists tell us would have been around \$1.8 trillion. That is the economic margin to give us the capability of doing what needs

doing to deal with the problems of poverty, and housing, and education, and all the others.

There are no economic Santa Clauses in the world. If a labor leader goes to the bargaining table and tells his people he can get more for them than the increase in productivity, he is either an economic moron or he is being dishonest to his rank and file. You can't get something out of nothing.

The only way you can have higher living standards, better social security, better medical care, better housing, better education, is for free men and women to determine to use the Nation's enormous economic power more effectively to generate the economic wealth to make them possible. The key to solving these problems is for America to find a way of achieving the objectives of the Employment Act of 1946, so that we can have full employment, full production, and maximum purchasing power, and begin to realize the full economic potential of the American economy which is, I think, freedom's greatest asset.

That is where the margin lies. But if we go on wasting millions and millions of man-hours of potential economic production—the American economy is operating now at 82 percent of its capability—and if we slow down the economy more to fight inflation, then we have chosen the wrong way to fight inflation. It will simply put the burden of inflation upon the backs of the poor who are least able to carry it, and the new people we have trained and taken out of the ghettos will be dumped back on the street again, and that would be a great tragedy.

Mr. CORMAN. Thank you.

One other question I have relates to the delivery of medical services. You have indicated the need for a national, I assume, compulsory health insurance program. I am wondering if we won't somehow have to change our whole philosophy of fees for services rendered regardless of the method that is used to pay those fees if we are ever really going to be able to deliver health services to the American people who need it.

Mr. REUTHER. I think one must admit that this is a very complex problem and that there are no simple answers. As we work developing our program, we are very fortunate to have helping us a special task force under the chairmanship of an outstanding authority, Dr. I. S. Falk, of Yale University. We have other able assistance. Two weeks ago we held a conference in New York which was attended by representatives of 65 national organizations including Blue Cross-Blue Shield, the insurance companies, and the American Medical Association. We are working on this with others because we don't claim to have all the answers.

National health insurance will require, in our judgment, a fundamental restructuring of the delivery system and we have to begin to build into that system the kind of meaningful and powerful economic incentive to bring about the reorganization of the use of our medical manpower with group practice and so that ultimately we will reorient the thrust of American medical care to reward doctors for keeping us well rather than to provide them with a built-in economic incentive to treat us when we get sick.

For example, we have the Kaiser Permanente group on the west coast, which is the largest prepaid group practice plan in America, the HIP in New York, which is the second largest, and a number of others

including a group in Detroit, of which I am privileged to be the president, called the Community Health Association. As is true of the other prepaid group practice plans, we have comprehensive health care. Our members are totally insured. The doctors have every reason and incentive to treat them and to take care of their health needs without putting them in hospital beds. We are providing very high quality health care, and the rate of utilization of our hospital beds and the rate of member utilization of hospital beds in the Kaiser Permanente and HIP is roughly 50 percent of that of Blue Cross subscribers because, unlike a group practice physician, a solo practice doctor paid on a fee basis has an incentive to put you in a hospital bed which may soon cost \$100 a day. Clearly the whole "non-system" has to be restructured and ultimately we have to think in terms of compensating doctors for keeping us well.

Mr. CORMAN. How does the incentive for the doctor work in Kaiser and the other two plans you have mentioned?

Mr. REUTHER. Well, the three plans are slightly different. In Kaiser they have what would generally be called a limited partnership. In other words, the doctors are on a basic salary, but at the end of the year they have a mechanism by which they share certain other funds based on the professional evaluation of each doctor's individual contribution.

In the HIP system in New York they have a different system and in Detroit our doctors are on a flat salary basis, although we are currently negotiating with them about a new arrangement which might be a limited partnership or some other system.

Mr. CORMAN. Do I understand correctly that this is substantially different from the normal fee for service rendered by a doctor to a patient?

Mr. REUTHER. Oh, yes. The doctor is paid to keep you well. He doesn't work on a piecework basis. The best doctor in the hospital who does the most difficult surgical operations does not get paid based upon how many people he can put through the assembly line. He gets paid for taking care of people's needs, which I think is a rational way to organize medical care.

Mr. CORMAN. Thank you very much.

Mr. ULLMAN. Are there further questions?

Mr. Chamberlain?

Mr. CHAMBERLAIN. Mr. Reuther, I was impressed with your suggestion on page 31 of your statement, as to the reinsurance of our private pension plans. I am wondering if in your research that you have done in support of this suggestion you have come up with any statistics that would reflect the scope of the need for legislation in this area that we could have here.

Just how bad is the situation at the present time? How many of our people have made investments in private pension plans and then have not received benefits at the appropriate time? Do you have any information on that?

Mr. REUTHER. We have some which we would be most happy to share with the committee or to any member of the committee. This involves many thousands of workers. If you just look at the automotive industry, you find the Hudson plant had to go out of existence, Packard went out of existence, Studebaker went out of existence, as well as many parts plants.

Mr. CHAMBERLAIN. Were all of these funds insolvent or were there no assets for the workers to share at that time?

Mr. REUTHER. There were assets, but the plans were not old enough to have had full funding of benefit liabilities. Under the normal termination provisions of the plans, the resources of a pension trust fund first are earmarked—and I think properly—to guarantee continued payment for the balance of the lives of all the people who are already on retirement and then giving the highest priorities to the oldest, most serious workers, they are allocated for the benefit of those who have not yet retired and who will be laid off when the plant is closed.

The result is that if a trust fund has only two-thirds of its benefit obligations funded and it requires the major share of that to guarantee a continuation of pensions for the people who are already on retirement, then there are insufficient resources left to cover fully the benefit equities of the workers who have yet not retired. We have cases and we can give you names of individuals.

We have one worker who was 59 years of age and who had worked for a company more than 40 years and yet he didn't get a cent out of the pension fund because it took all the moneys in the trust fund to guarantee the pension benefits of the people who had already retired.

The cost of pension reinsurance would be minimal if it were spread over total private payrolls, in the same way we spread the cost of insuring bank deposits over the total banking system.

Mr. CHAMBERLAIN. I think, Mr. Reuther, it would be helpful if we could have that for our record as well as the specific data that you have with reference to the cost of such a program. Just pursuing this with one further question: Is the concept of mobility included in these private pension plans? Have you done any work in this area?

Mr. REUTHER. Yes, we have, and we believe that it is possible to workout provisions in the private pension plan sector to facilitate maximum worker mobility. I can think of no more tragic figure in a free society than a worker who is really chained to a job because he can't afford to forfeit his pension benefits. We have been working to correct that. In our NAW pension plans, we now have vesting after 10 years so that a worker can move after that length of time. But why should a worker lose his pension credits if he wants to move after 5 years? We think that there ought to be provisions to enable workers to have maximum mobility so that they can upgrade their skills, move to more attractive or better paying jobs without forfeiting or sacrificing any of their pension equities.

Mr. CHAMBERLAIN. I would personally appreciate such information as you may have on that subject.

Mr. REUTHER. I shall see that you get it.

Mr. CHAMBERLAIN. Thank you.

Mr. ULLMAN. Without objection, the material will be placed in the record.

(The material referred to was not received in time for printing.)

Mr. REUTHER. Very well.

Mr. ULLMAN. Thank you very much, Mr. Reuther. Your testimony, as usual, has been most helpful to the committee.

Mr. REUTHER. Thank you for the opportunity.

Mr. ULLMAN. Mr. Abel, the committee will be very happy to hear you at this time.

Mr. Corman?

Mr. CORMAN. Mr. Chairman, I would like to welcome Mr. Abel to this committee. It was my privilege to have served with him on the Kerner Commission some 2 years ago. He made a great contribution to that commission with his recommendations, and I am looking forward to hearing his testimony today.

STATEMENT OF I. W. ABEL, PRESIDENT, UNITED STEELWORKERS OF AMERICA; ACCOMPANIED BY MURRAY LATIMER, ACTUARIAL CONSULTANT, AND JOHN J. SHEEHAN, LEGISLATIVE DIRECTOR

Mr. ABEL. Thank you.

Mr. ULLMAN. Mr. Abel, we certainly do welcome you before the committee. Would you please identify your colleagues and proceed as you see fit, sir?

Mr. ABEL. Thank you, Mr. Chairman. My name is I. W. Abel. I am president of the United Steelworkers of America, and I am accompanied this morning by Mr. Murray Latimer, our actuarial consultant, and Mr. Jack Sheehan, our legislative director.

Mr. ULLMAN. We are very happy to have these gentlemen with you, Mr. Abel. You may proceed.

Mr. ABEL. Thank you, sir.

Mr. Chairman, we have submitted a technical statement to your committee, and I do not propose this morning to go over that statement. I want to make a summary of it.

Mr. ULLMAN. Mr. Abel, without objection, this material will appear in full in the record.

Mr. ABEL. Thank you, Mr. Chairman.

An adequate and fair Social Security Act is a priority concern of the United Steelworkers of America. Some 170,000 of our members are now drawing pensions under plans that we have negotiated with our employers, and more than 150,000 of them are also paid social security benefits. More than 270,000 of our members have been retired under our pension programs since the first one of them began to operate in 1950.

The United Steelworkers of America joins with the national AFL-CIO in support of the liberalization of the benefits provided under title II of the Social Security Act.

In my brief testimony today I want to emphasize three matters in which steelworkers have a special interest.

The first has to do with the dropping out of periods of low or no earnings.

The second has to do with the definition of disability for purposes of the disability insurance benefit.

The third concerns the offset to workmen's compensation benefits against social security disability insurance.

The dropping out of periods of low or no earnings, I believe, works an injustice upon those who retire or who become disabled before they attain eligibility for old-age insurance benefits.

For example, the retirement of an employee after a disability which does not qualify as such by social security standards may not only deprive the employee of current income but reduces the amount of his old-age insurance benefit by diminishing his average monthly wage. In addition to the adverse effects upon the disability, the dropping

out of periods of low or no earnings penalizes those employees who have the right to retire voluntarily before age 65.

Under many of our plans an employee can become entitled to a pension as early as 47 or 48 years of age. In industries where job opportunities are decreasing, it is to the advantage of everyone, in our opinion, that early retirement not only be permitted but that it be encouraged. If early retirement is to be realized, the full pension must be paid, and that is what our negotiated plans do.

But, of course, that is not the case with social security. And I would like to be specific about how the present law works to the disadvantage of a person who retires before he is eligible for social security.

If an employee retires at age 50, as an example, if he is not entitled to a disability insurance benefit, if he has no further employment under social security, his average monthly wage will be continuously reduced until he does become eligible for social security.

For example, if an employee retires at the end of this year and reaches age 65 in January 1970, if he has had maximum credible wages each year since 1950, his primary social security benefit would be \$165 a month. But if he is only 50 years of age when he retires and applies for social security at the age of 65 without working in covered employment between ages 50 and 65, his primary benefit would be only \$119.80. In other words, there is a built-in penalty for workers who retire before they can receive social security benefits.

This, it seems to us, goes against the present-day trend toward earlier and earlier retirement, and it tends to decrease job opportunities at a time when we should be more concerned about increasing job opportunities. When we contemplate today's ever-increasing emphasis by industry upon automation and utilization of new technology, toward more reliance upon machines than upon man, the need for increasing employment opportunities becomes more urgent.

The failure to drop out periods of low or no earnings also is unfair for another reason. A worker who contributes to the fund for fewer years but who delays retirement until age 65 can receive a higher social security benefit than a worker who has paid more into the fund but who retires earlier.

I think this is one of the unfairest sections of the Social Security Act. I think it flies in the face of today's realities. I urge most strongly that this provision receive the utmost serious attention of the committee.

A number of Representatives have introduced legislation which deals with the method of calculating average monthly wages. The drop-out is increased from 5 years to 5 years, plus 1 year for each 40 quarters of coverage. The procedure is the same for men and women employees alike.

This is how provisions of the proposed bill would apply in the example I just cited, where the social security payment was \$119.80. If the proposed bill were in effect and the employee had 30 years of continuous employment and all quarters were quarters of coverage, the primary amount would be \$137.80 instead of the \$119.80 that I cited earlier. This would be an increase of 15 percent over the provisions currently in force for men. But, of course, it is still far short of the benefit payable on the identical wage record to a man who retires at age 65 instead of age 50.

But the proposed legislation is the right step in the right direction.

On disability, we turn to the question of defining "disability" for the purpose of the disability insurance benefit. I am sure that the social security definition of "disability" has been very carefully drawn to prevent the payment of benefits to persons who while unable to perform the duties of their own employment could do some kind of work if they could find and get it, work which exists somewhere in the national economy.

The problem for such individuals is to find the work and then having found it to get it. The huge majority of our members who are retired because of disability do not in fact every find any sustaining employment even if denied social security.

There has been a cloud hanging over any insurance against the risk of disability dating back to what has been regarded as the unfortunate experience of insurance companies during the depression of the 1930's. There is no doubt that the rate of pensionable disability increases as unemployment rises. There is no doubt either that the disability is there at all times but that people generally prefer to work rather than receive pensions even when suffering from substantial disability.

It is only when there is no work that the strong preference for income over the lack of income begins to operate. It is those occupationally disabled people who normally work but who have had to get out of the labor force with whom I am concerned and for whose welfare I ask action from this committee.

According to the 1966 disability survey, there were 1,700,000 severely disabled males not in the labor force as compared with 120,000 occupationally disabled males.

Mr. Chairman, this is a very small number that would be added to those receiving benefits, only about 7 percent of those now eligible. A less rigid interpretation of the law would provide this 7 percent with the help they desperately need.

I do not advocate payment of disability benefits to individuals who could reasonably be expected to find work which they are capable of doing. What I ask is that where an employee has been found under reasonably physical and mental standards permanently unable to perform any of the work which he could get if he were not disabled, that he be made eligible for disability insurance benefits. I would agree that those who are responsible for disability determination under social security should verify the reasonableness of the standards used to disqualify employees and the fact that an individual could not meet them.

In other words, Mr. Chairman, the Social Security Administrator should have the right to check the guidelines used by employers to declare a worker disabled. This, of course, would also give unions the opportunity to protect jobs of workers unreasonably discharged on the ground of occupational disability.

With appropriate safeguards, it might be practical to have the head of the employment service and of the rehabilitation service in the area in which the applicant resides join in the certification that there is no job within a reasonable geographic area to which the applicant can be referred with any possibility of being hired.

The changes I suggest are matters of degree. Every day applicants are awarded disability insurance benefits under the current rigorous standards who would be employed full time if we were in the midst of

an all-out war. There are individual workers working full time now when the economy is operating at a high level who will qualify for disability if they become unemployed, even though their mental and physical characteristics do not change.

What is important is that an individual has no job and, barring war and an overheated economy, will never have a job because he has a disability. Once that fact is established by reasonable proof, the benefit ought to be payable.

Now a few words about the offset of workmen's compensation. If a worker is entitled to disability benefits under title II and also entitled to workmen's compensation at the same time, the disability insurance may be reduced. It is reduced so that the total of disability benefit plus any benefits payable under title II to his dependents will not exceed the higher of 80 percent of his average current earnings, or the total of his title II benefits. The limit of total benefits is adjusted periodically if wage levels move upward.

This provision has been a troublesome one. It is inequitable as between individuals whose levels of compensation differ. The provision also discriminates against those who are disabled from occupational injuries or diseases without affecting those disabilities that are not work connected.

Large numbers of employees are covered by group life insurance, which provides that if an employee becomes totally disabled for any reason for 6 consecutive months, the face amount of his insurance will be paid to him. These insurance benefits would not be affected by the employee's eligibility for disability insurance benefits under title II.

Some of the recently developed long-term disability policies provide benefits not affected by social security disability benefits at all. Many self-employed persons have individual policies providing disability income which are not coordinated with social security. The provisions discriminate against individuals with one or more dependents.

Social security disability benefits include substantial payments for wives, husbands, and children. A number of States supplement workmen's compensation with payment for dependent children.

To the extent that 80 percent of the average current earnings constitutes a limit on the disability insurance payment, these benefits for dependents are more likely to bring it into operation for individuals with dependents. Therefore, the aim of dependents' allowances to provide needed extra income is defeated.

Some of our members have been seriously affected by workmen's compensation offsets against the benefits of an individual when his entitlement to workmen's compensation is questioned. At present until the question is resolved, disability benefits are not paid.

The social security amendments of 1967 improved the definition of "average current earnings," but the method of updating the "average current earnings" was not modified. If the limit on taxable wages were to be regularly adjusted so as to include some specified percentage of total wages and salaries, the formula for redetermination might operate reasonably well. But as long as the limit is not so fixed, it will have serious disadvantages.

The average of total wages of all employees covered by social security has some disadvantages. It is reduced by unemployment and by the trend toward greater part-time employment. In my opinion, the best disposition of the workmen's compensation offset would be, of

course, to eliminate it. The least that should be done is to make it reasonably fair. To that end, if it is retained, I would like to suggest five modifications in the present provisions.

First, that the limit of 80 percent of average current earnings be raised to 100 percent; second, that in determining the benefit to be compared with the limit, any benefits payable to or on account of dependents be excluded; third, that the method of calculating the average current earnings be improved by basing it on the compensation in the highest 24 months of the 5 years of highest earnings picked out by the present method; fourth, that there be developed an index of straight time hourly compensation per employee man-hour for use as the factor to adjust average current earnings; and, finally, that where payments of workmen's compensation are suspending the determination of continued entitlement, social security disability benefits which have been reduced should be paid in full, subject to reimbursement if the suspension is found to be improper.

There will, of course, be objection to the payment of full compensation on the ground that it will discourage return to work. This danger has always been greatly exaggerated. With present medical techniques, I believe any such danger to have substantially disappeared.

The purpose of benefits for dependents is to provide support for them, and that purpose is not fulfilled if payment is prevented by a limit. The Bureau of Labor statistics has developed an index of the compensation per employee man-hour in private nonfarm economy. This index should be modified by the elimination of the premium part of overtime pay.

In cases where a worker is entitled to workmen's compensation for a period where social security disability benefits were paid, no particular difficulties appear to have been encountered in securing repayment of benefits. It would seem to me that satisfactory arrangements can be made for such repayment if benefit offsets are suspended during the period when there is an unresolved dispute over continued entitlement to workmen's compensation.

Mr. Chairman, in conclusion of my oral testimony here this morning, I would like to state that we did ask Mr. Latimer in preparing our material to try to estimate some of the costs. I would just like to call attention and take a little more of the time of the committee to just read the last three paragraphs of Mr. Latimer's calculation on the costs of these proposed improvements in social security.

He advises us after extensive study that all this adds up to an increase in the tax schedule for old-age and survivors and disability insurance of the order of three-tenths percent each on employers and employees.

I realize that in terms of dollars, this increase seems very large, but I would emphasize that we are concerned here in large measure with persons who have been seriously and adversely affected for long periods of disability and unemployment and who as a result are among the most disadvantaged of all those covered by social security.

Social security embodies some transfer of income from the more prosperous to those who have shared little, if at all, in our affluence. What I suggest would enlarge that transfer to a very modest extent.

The contributions to the old-age and survivors and disability insurance trust funds in the year ended June 30, 1969, were a little less than

4 percent of the national income during that same period. What I have advocated here, if it had been operative for the full year, would have increased that percentage from about 4 percent to about 4.25 percent. This, I submit, is a small price to pay for a great improvement in the lives of some of the most needy among us.

Mr. Chairman, this concludes my oral testimony this morning, and I, of course, want to express to you and the members of the committee our appreciation for this opportunity to appear this morning.

(The statement referred to follows:)

STATEMENT OF I. W. ABEL, PRESIDENT, UNITED STEELWORKERS OF AMERICA

No federal legislation is more important for the members of the United Steelworkers of America than the Social Security Act. Some 170,000 of our members are now drawing pensions under plans we have negotiated with our employers, and more than 150,000 of them are also paid Social Security benefits. More than 270,000 of our members have been retired under our pension programs since the first one of them began to operate in 1950. The widows of many pensioners who have not survived are entitled to Social Security widows' benefits. Finally, there are the widows and children of members who died while in active service. Social Security benefits to retired members of the United Steelworkers of America, their dependents and to survivors of members who have died are now in the area of \$300 million annually. The Social Security taxes paid by our members who are under our negotiated pension plans, together with the employer taxes, will come to about \$400 million in 1969.

We join with the American Federation of Labor in support of the liberalization of the benefits provided under Title II of the Social Security Act. I want to emphasize particularly three matters in which Steelworkers have a special interest. The first of these has to do with the exclusion of periods when an employee has low earnings or no earnings in connection with the calculation of his average monthly wage. The second relates to the offset of workmen's compensation benefits against Social Security disability insurance, while the third is concerned with the definition of disability for purposes of the disability insurance benefit.

I. EXCLUDING PERIOD OF LOW EARNINGS FROM THE AVERAGE MONTHLY WAGE CALCULATION

The average monthly wages of employees who retire on old-age insurance benefits between the ages of 62 and 65 are now calculated in the overwhelming majority of cases by dividing their total creditable wages in their benefit computation years by the total number of quarters in such years. The benefit computation years run from 1951, or the year after an employee is 21, if later, to the end of the year preceding the 65th birthday. For a female employee the end of the benefit computation years in connection with age retirement is the year preceding her 62nd birthday. In both cases the 5 years of lowest earnings may be excluded from the calculation.

The retirement of an employee for a disability which does not qualify as such by Social Security standards may not only deprive the employee of current disability income, but reduces the amount of his old-age insurance benefit by diminishing his average monthly wage. In some cases there may even be disqualification for old-age insurance entirely if the disability and retirement occur at a relatively early age. Much of this adverse effect of disability on old-age income would be remedied if the definition of disability were to be modified along the lines I will suggest and the whole benefit payment period were to be eliminated, as it now is, from the benefit computation years.

But the problem is not confined to those individuals who become disabled before they attain eligibility for old-age insurance benefits. Under many of our pension plans, as well as in the plans of other industries, some employees have the right to retire voluntarily before they are 65. In many of our plans the requirements for retirement on pension relating to employees permanently displaced by employer action are such as to provide pensions at a relatively early age. Under many of our plans an employee can become entitled to a pension as early as age 47 or 48. In industries where employment opportunities are decreasing or where the work is particularly onerous it is, in my opinion, to the advantage of every-

one that early retirement be permitted. And provision for early retirement at ages under 60 on benefits which are the actuarial equivalents of those payable at 65 is giving the form without substance. If early retirement is to be realized, the full pension must be paid. And that is what our negotiated plans do. But that, of course, is not the case with Social Security.

If an employee retires at age 50, is not entitled to a disability insurance benefit, and has no further Social Security employment, his average monthly wage will be continuously reduced until he becomes (or could, upon application, become) entitled to a Social Security benefit. If an employee retires at the end of this year and attains age 65 in January 1970, his primary Social Security benefit, if he has had maximum creditable wages each year since 1950, would be \$165 per month. But if he attains age 50 in 1970, his Social Security monthly primary benefit, if he applies for it at 65 (in 1985), without intervening covered employment, would be only \$119.80. Under identical circumstances the Social Security primary benefit for a woman would be \$127.10 instead of \$119.80.

Senator Hartke has introduced S. 3035 which deals with the method of calculating average monthly wages. The exclusion from the benefit computation years is increased from 5 years to 5 years plus 1 year for each 40 quarters of coverage, and the procedure for men is made the same as for women. If, in the illustration just given where the Social Security primary amount is currently \$119.80, the provisions of the Vanik Bill were to be substituted, and if the employee involved had 30 years of continuous employment in which all calendar quarters were quarters of coverage, the primary amount would be \$137.90. This is an increase of about 15 per cent over the provisions currently in force for men, but it is still far short of the benefit payable on the identical wage record to a man 15 years older than the employee used in the illustration.

II. OFFSETTING WORKMEN'S COMPENSATION AGAINST SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

If an individual entitled to disability insurance benefits under Title II is concurrently entitled to workmen's compensation benefits under federal or state law, the disability insurance benefit is reduced (unless the state law reduces the workmen's compensation because of the receipt of the Title II disability benefits) so that the total of such Title II disability benefit plus any benefits payable under Title II to dependents of the disabled individual on the basis of his wages will not exceed the higher of (i) 80 per cent of the "average current earnings," or (ii) the total of Title II benefits payable to him and to others on account of his wages. The limit on the total of benefits may be adjusted periodically if wage levels move upward.

This provision has been a troublesome one. It has been at one stage more stringent and at another more liberal than it is at present. I suggest it is not yet what it ought to be. It is inequitable as between individuals whose levels of compensation differ. Under almost all workmen's compensation laws there is a relatively low maximum benefit; and as late as 1967 the OASDI limit covered the full remuneration of only about 75 percent of all participants. The higher the remuneration, the less likely is an individual to be affected by the limit. That is, there is discrimination against the low paid.

The provision discriminates against those who are disabled from occupational injuries or diseases without affecting those whose disabilities are not work connected. Large numbers of employees are covered by group life insurance which provides that if a covered employee becomes total disabled for any reason for 6 consecutive months, the face amount of his insurance will be paid to him, usually in equal installments, over a 5-year period. These insurance benefits are not affected by the employee's eligibility for disability insurance benefits under Title II. Some of the recently developed long-term disability policies provide benefits to the policyholder which are not reduced by his receipt of Social Security disability benefits. Many self-employed persons have individual policies providing disability income which is not coordinated with Social Security.

The provisions discriminate against individuals with one or more dependents as compared with those without dependents. Social Security disability insurance benefits include substantial payments for wives, husbands and children. There are a number of states which add supplements to workmen's compensation payments for dependent children. Obviously, to the extent that the 80 per cent of average current earnings constitutes a limit on the disability insurance payment, these benefits for dependents are more likely to bring it into operation for individuals with dependents than where there are no dependents or fewer of

them. And, to the extent that the limit operates, the aim of dependents' allowances to provide needed extra income is defeated.

Some of our members have been seriously disadvantaged by the requirement that workmen's compensation offsets be made against the benefits of an individual on the basis of a notice of his entitlement to workmen's compensation when, after such notice is given, that entitlement is questioned. When an insurer challenges continued entitlement and stops payment of workmen's compensation, for example, and the individual involved contests the validity of that action, there is likely to be an extended period of uncertainty as to whether or not workmen's compensation is payable. At present, until the question is resolved, Social Security disability benefits are not paid because the notice of entitlement has not been canceled and the insurer (or the employer, if self-insured) may refuse to pay until the state agency rules. Social Security will make retroactive adjustment if the insurer's action is upheld, and the insurer will likewise make the proper payments if overruled. Meanwhile, the disabled employee suffers.

The Social Security Amendments of 1967 improved the definition of "average current earnings" by permitting the inclusion of wages and self-employment income in excess of the limit imposed for the purpose of calculating the average monthly wage. But the method of updating the "average current earnings" was not modified. The "average current earnings" are to be redetermined from time to time by multiplying the initial average of the ratio of (i) average taxable wages under OASDHI for the first quarter of the year in which the redetermination is made to (ii) the average of such wages for the first quarter of the year in which the "average current earnings" were first computed. If the limit on taxable wages were to be regularly adjusted so as to include some specified percentage of total wages and salaries, this formula for redetermination might operate reasonably well. But as long as the limit is not so fixed it will have serious disadvantages. For example, for the 7 years 1959 through 1965 the limitation on taxable wages was \$4,800 per annum. During that period average taxable wages rose by 10.1 per cent, but average total wages increased by 21.1 per cent. If redeterminations had been permitted during that period and the present formula had been used, the aim of updating the benefit to reflect increases in what the beneficiaries' realistic wage losses were would not have been achieved. On the other hand, when the taxable wage limit was raised in 1966 from \$4,800 to \$6,600 there was an artificial spurt resulting from the formula. Between 1964 and 1966 the average total wages increased by 8.7 per cent, but average taxable wages jumped 20.5 per cent.

The average of total wages of all employees covered by OASDHI has some disadvantages. It is reduced by unemployment and by the marked trend in recent years toward greater part-time employment. In the other direction the average is increased over what can appropriately be used as a base against which to measure wage losses by overtime.

In my opinion, the best disposition of the workmen's compensation offset would be to eliminate it. The least that should be done is to make it reasonably fair. To that end, if it is retained, I suggest five modifications in the present provisions. First, that the limit of 80 percent of "average current earnings" be raised to 100 percent; second, that in determining the benefit to be compared with the limit, any benefits payable to or on account of dependents be excluded; third, that the method of calculating the "average current earnings" be improved by basing it on the compensation in the highest 2 years, whether or not consecutive, in the 5 years of highest earnings picked out by the present method; fourth, that there be developed an index of straight-time hourly compensation per employee man-hour in private non-farm economy for use as the factor by which to adjust "average current earnings"; and finally, that where payments of workmen's compensation are suspended pending determination of continued entitlement. Social Security disability benefits which have been reduced on the basis of that entitlement be paid in full, subject to appropriate arrangements for reimbursement if the suspension of workmen's compensation is found to have been improper.

There will, of course, be objection to payment of full compensation on the ground that it will impede return to work. This danger was always greatly exaggerated; with present medical techniques I believe it to have substantially disappeared. The purpose of benefits for dependents is to provide support for them. That purpose is negated if payment is prevented by a limit. With wages increasing at the rates of recent years, even a 5-year average base results in incomplete measurement of wage losses of a disabled individual. The situation is even more serious if the disability is the result of a condition which is not caused by a sudden injury, but it is progressive, resulting in a continuously increasing loss

of work time or demotions to less demanding jobs, or both. The Bureau of Labor Statistics has developed an index of the compensation per employee man-hour in private non-farm economy. My suggestion is that this index be modified by the elimination of the premium part of overtime pay. In cases where entitlement to workmen's compensation is found to exist for a period when Social Security disability benefits were paid, no particular difficulties appear to have been encountered in securing repayment of benefits. It would seem to me that satisfactory arrangements can be made for such repayment if benefit offsets are suspended during a period when there is an unresolved controversy over continued entitlement to workmen's compensation.

III. CHANGING THE DEFINITION OF DISABILITY FOR THE PURPOSES OF DISABILITY INSURANCE BENEFITS

This year about 3,000 steelworkers have been or will be retired while under 65 on a company pension, payable pursuant to agreements negotiated by our Union, because they have become physically or mentally incapacitated for the performance of their duties. In the basic steel, aluminum and can industries, disability, which is compensable under our agreements, is defined as permanent incapacity for engaging in employment of the types covered by our basic labor agreements or, in some cases, of the type to which the retiring employee's seniority gives him some rights. All of the 3,000 employees who have been awarded disability pensions will apply for disability insurance benefits under Title II of the Social Security Act. About 700 of these applications have been or will be denied on the ground that, insofar as Social Security is concerned, no disability exists. There will be no question that these 700 employees are severely disabled or that they are unable to carry on in any occupation in the plant where they work. Some of these plants are very large and carry on work requiring a tremendous range of skills and experience. We contend in may of these cases that there is no substantial gainful employment of any character whatsoever in which they are able to engage. Why some of them are denied benefits we frankly cannot understand. We have had more than a few cases in which the denial of Social Security disability benefits on the ground of insufficient disability has been proved wrong by the prompt death of the applicant from that allegedly mild disability.

I should explain that until about 5 years ago our pension agreements defined disability as permanent incapacity, for physical or mental reasons, for engaging in any occupation or employment for remuneration or profit. The percentage of Steelworker applicants for Social Security disability benefits who were denied benefits because of not being disabled was about the same under the old definition (which still applies in the copper industry and in many of our pension agreements with small companies) as it is today.

I am aware that the Social Security definition of disability has been very carefully drawn to prevent the payment of benefits to persons who, while unable to perform the duties of their own employment, could, if they could find and get it, do some other kind of work—work which exists somewhere in the national economy. The problem for such individuals is to find the work, and having found it, get it. The huge majority of our members who are retired because of disability do not, in fact, ever find any sustaining employment, even if denied Social Security. Those who are 62 or older usually take a reduced Social Security benefit. In the basic steel, aluminum, can, copper and in some other of our pension it, get it. The huge majority of our members who are retired because of disability pensioners who are found to be ineligible for Social Security disability insurance benefits, the payments continuing until the pensioner is 65, even if he elects a reduced Social Security benefit before he attains that age. The supplement, \$130 per month in the copper industry and \$75 per month everywhere else, does not make the disability pensioner whole. The benefits are smaller—at \$75 less than half of the usual primary Social Security disability benefit for which our members qualify—and there are no dependents' supplements. And the average monthly wage on which the Social Security benefit is based is, as I have already explained, reduced.

There has been a cloud hanging over any insurance against the risk of disability dating back to what has been regarded as the unfortunate experience of insurance companies during the depression which began 40 years ago. It was reflected in our first steel pension agreements in which we recited that "a pension shall not be granted . . . for the purpose of providing an employee relief

from unemployment or any condition other than permanent incapacity for medical reasons." We have long forgotten this provision of 20 years ago, as have the employers with whom we deal. There is no doubt that the rate of pensionable disability increases as unemployment rises. There is no doubt either that the disability is there all the time, but that people generally prefer work, even when suffering from substantial disability, to a pension. It is only when there is no work that the strong preference for income over the lack of it begins to operate. Nor is there any question that once a substantially disabled person is out of work, the chance of his resuming employment when the business of his employer picks up is small, even if he can hold on to his seniority. To get a new job with another employer is close to impossible; that is, when unemployment strikes, many disabilities which had been partial become total and permanent in relation to any substantial gainful employment.

The problem of persons too disabled to work, but not disabled enough to qualify for present Social Security disability insurance benefits, is not peculiar to the steel industry. In the Social Security Bulletin for May 1968, findings from a survey in the spring of 1966 made by the Bureau of the Census for the Social Security Administration indicated that about 6,000,000 adults (2,300,000 men) among those 18 to 64 years of age not in institutions were so severely disabled as not to be able to work regularly. Four of each five (seven out of ten among the men) were too disabled to be in the labor force at all. Among the occupationally disabled, one of three (only one in twenty males) was not in the labor force. Housewives and others who had never worked or worked for only very brief periods are included among the disabled. The number of Social Security disability insurance benefits being paid to retired male workers who were severely disabled and out of the labor force was relatively twice as large as the number being paid to those occupationally disabled and retired. The corresponding ratio for females was over 22 to 1, no doubt reflecting the inclusion in the survey of many women who were never in the labor force or who left the labor force before becoming disabled.

It is those occupationally disabled persons who normally work, but who have had to get out of the labor force, with whom I am concerned and for whose welfare I ask action from this Committee. According to the 1966 disability survey, there were 4,900,000 severely disabled individuals not in the labor force (1,700,000 of whom were men) as compared with 1,700,000 occupationally disabled (including 120,000 men). The inclusion of housewives in the census who will not qualify in that capacity for Social Security benefits again distorts the picture. On the basis of male members, the occupationally disabled who have been forced out of the labor market constitute about 7 per cent of the severely disabled.

When the 1966 survey of the disabled was made the Title II definition of disability was not what it is today; the 1967 amendments had not been enacted. While the intent of this Committee in formulating the disability insurance provisions of Title II may have been unchanged over the years, the courts had construed the phrase "inability to engage in any substantial gainful activity" to permit the payment of benefits to persons whose inability to work was the result not entirely of the disability as such but, to some extent, of employers' hiring practices and policies, or of the nonexistence of particular types of jobs within the area to which the person involved had reasonable access. In a leading case the court held that performance of what the Social Security Administration classified as substantial employment was compatible with being disabled. If the current definition had been used, the proportion of occupationally disabled might have been somewhat larger than 7 per cent of those classified in the "severe" category.

I do not advocate payment of disability benefits to individuals who could reasonably be expected to find substantial work which is within their competence. What I ask is that where an employee has been found, under reasonable physical and mental standards, permanently unable to perform any of the work which he could get if he were not so disabled, he ought to be found to be eligible for disability insurance benefits. I would agree that those who are responsible for disability determinations under Social Security should verify the reasonableness of the standard used by employers to disqualify employees and verify the fact that an individual could not meet them. Nor would I object to a review of the training and experience of an individual who had been disqualified for his employment to verify that a real disability is the basis for that disqualification—not mere loss of seniority. This procedure would, of course, enable unions to protect members arbitrarily discharged because of alleged disability. If the Social Security Administration found that the standards for determining

disability were unreasonable or that a worker was not genuinely disabled under standards which were reasonable, we doubt if many of our grievances on disability would have to go to arbitration, or if that were necessary, that we would lose. With appropriate safeguards it might be found practicable to have the head of the employment service and of the rehabilitation service in the area in which the applicant resides join in a certification that there is no job within a reasonable geographic area (absent some arrangement for covering any expenses involved in accepting a job outside the area) to which the applicant can be referred with any possibility of being hired.

The changes I suggest are matters of degree. Every day applicants are awarded disability insurance benefits under the current rigorous standards who would be employed full time if we were in the midst of an all-out war. There are individuals working full time now when the economy is operating at a high level who will qualify for disability if they become unemployed, even though their mental and physical characteristics do not change. What is important is that an individual has no job, and barring war and an overheated economy, will never have a job because he has a disability. Once that fact is established by reasonable proof, a benefit ought to be payable. I take it for granted that the rehabilitation trial work and suspension of benefit provisions would apply and would perhaps be more productive on the cases which would qualify because of the change in definition than on cases which are eligible under present rules.

I am here advocating the principle that if, because of disability, an individual is without hope under reasonably foreseeable circumstances of securing sustaining employment, he should be made eligible for disability insurance benefits. If that principle is accepted, its implementation, I am sure can be worked out satisfactorily.

IV. COST CONSIDERATIONS

I have asked our actuarial consultant to give me some estimate of the cost of the amendments which I am suggesting in this statement. As to the first proposal, he tells me that the cost of excluding longer periods from base computation years is affected by the average rate at which the compensation of individual workers increases; by the extent of unemployment and part-time employment, and whether or not spread out over long periods or concentrated in a few years; and by the rate of withdrawal of individuals from covered employment after acquiring sufficient quarters of coverage to qualify them for a benefit, but with a longer or shorter period of time elapsing between the withdrawal and the beginning of benefits. The most important of these factors is the rate and distribution, over time, of unemployment, including unemployment resulting from illness and other disability. The rate of compensation increase is not a crucial factor. The preponderance of individuals leaving covered employment are women, and their participation has been increasing in recent years after showing little movement for 15 years. The rate of unemployment in the 60's, if continued indefinitely, would mean relatively low costs for this amendment—of the order of 2 to 3 percent of the total costs of the old-age and disability insurance benefits, even taking into account the fact that the average length of the benefit computation period will, because of the new start provisions, be gradually increasing for many years. If the average level of unemployment rises to that of the 1950's, costs might increase in the range of 2½ to 3½ percent. It seems unnecessary to consider costs under any assumption that the level of unemployment will become higher than in any post-war period covering an entire cycle of business activity.

As to the workmen's compensation offset, workmen's compensation cases constitute a very minor fraction of all Social Security disability benefit awards, may terminate long before the disability benefit, and in any event end not later than the beneficiary's attainment of age 62. By no means all compensation recipients have their Social Security benefits reduced. Even if the workmen's compensation offset were to be eliminated entirely, an increase in Social Security disability insurance costs of the order of 3 percent is regarded as a reasonable expectation—hardly enough to increase the tax rate.

Our consultant informs me that as to the third amendment, the Railroad Retirement Act affords some apparently relevant experience. There has been provision in the Railroad Retirement Act for over 20 years for award of pensions based on occupational disability retirement. I am told that the most recent published experience indicates that the total disability rate in the age groups in which a pension may be awarded on the basis of occupational disability exceeds the rate of total disability by 86 percent at ages 45-49; by 36 percent

at ages 50-54; and by 37 percent at ages 55-59. At ages 60 and over no separation has been made as between occupational and total disability, but it is generally supposed that the differences between occupational and total disability rates at those ages are less than at younger ages.

Occupational disabilities do not reduce longevity as much as total disability. But the possibility of rehabilitation of the occupationally disabled should operate to reduce somewhat the length of the benefit payment period. Our consultant's conclusion is that if Social Security experience were to duplicate that of Railroad Retirement, the expansion of the definition of disability which I have advocated would raise disability insurance costs by from 60 to 75 percent. But, he hastens to add, he does not think Railroad Retirement experience would be applicable.

First, public safety necessities are such as to impose unusually high physical standards on train and engine service crews which constitute a significant fraction of total railroad employment. Engineers and firemen, conductors and brakemen, can be and frequently are disqualified for reasons which would not be noticed in most occupations. Further, the skills in the train and engine service occupations are not readily transferable and have little application outside the railroad industry.

Second, the adjudication standards of the Railroad Retirement Board are such as to find occupational disability to exist even when the identical skill can be used in another industry. Thus in requesting amendments to the limits on allowable earnings, the Railroad Retirement Board cited numerous cases of former railroad employees who were receiving disability pensions and at the same time earning as much in their regular occupation as they had earned in railroad employment. Under the amendment I advocate this could not occur.

Third, there has been an almost continuous reduction in railroad employment during the entire period of operation of the occupational disability provision. Unemployment, as I have pointed out, always tends to raise the rate of disability.

Our consultant believes that the increase in Social Security disability insurance costs arising from adoption of the amendments I suggest in relation to the definition would be not more than 40 percent—perhaps as little as one-third. This means an increase in the tax on employers and employees of 0.2 percent each.

All of this adds up to an increase in the tax schedule for old-age, survivors and disability insurance of the order of 0.3 percent each on employers and employees.

I realize that in terms of dollars this increase seems very large. But I would emphasize that we are concerned here in large measure with persons who have been seriously and adversely affected for long periods by disability and unemployment and who, as a result, are among the most disadvantaged of all those covered by Social Security. Social Security embodies some transfer of income from the more prosperous to those who have shared little, if at all, in our affluence. What I suggest would enlarge that transfer to a very modest extent.

The contributions to the old-age and survivors and disability insurance trust funds in the year ended June 30, 1969, were a little less than 4 percent of the national income during the same period. What I have advocated here, if it had been operative for the full year, would have increased that percentage from about 4 to about 4.25. This, I submit, is a small price to pay for a great improvement in the lives of some of the most needy among us.

Mr. ULLMAN. Mr. Abel, let me express our appreciation for your very thoughtful discourse and your recommendations on three very troublesome areas in the social security system. I want to say, as one member of the committee, I agree with your recommendations.

Are there questions?

Mr. Burke?

Mr. BURKE. I wish to commend you, Mr. Abel, for your statement and pointing out one of the real problems in the social security handling of the law.

I imagine with the steelworkers, where it is such heavy work, that you find many of your members when they reach the age of 50, with the hazards in the industry, many of these men are disabled and unable to continue on in their work.

What do you find the attitude is of most employers in this Nation on hiring people over 50 years of age?

Mr. ABEL. In our industry up until this current year it has been one of almost refusal to hire. But in this last year, because of the tempo of the economy and the shortage of workers in some areas, notably Gary, Ind., they have dropped the bars considerably. But the normal thing is to reject employees past age 35, I would say.

Mr. BURKE. Actually, with the disability and the fact that they are not able to meet the strict requirements of the social security law to be eligible for disability benefits, the worker who is over 35 years of age normally finds a difficult time to even be interviewed for a job, let alone be hired.

Mr. ABEL. Correct.

Mr. BURKE. So I think that you struck a good point here today, and it is a matter that has concerned some members of this committee for many years. And I am hopeful that we will be able to do something about it.

Mr. ULLMAN. Mr. Schneebeli?

Mr. SCHNEEBELI. Mr. Chairman, back in Pennsylvania, Mr. Abel has an excellent reputation as being a very fair and far-sighted individual and has the respect of all groups in the State of Pennsylvania—management, labor, social-minded people, elected officials—and they all have a high regard for his sense of fairness and equity.

Thank you very much Mr. Abel for bringing us this very practical and realistic approach to some of the problems that we have here. You made quite a contribution. Thanks for coming.

Mr. ABEL. Thank you, sir.

Mr. BURKE (presiding). Mrs. Griffiths?

Mrs. GRIFFITHS. I would like to commend you too, Mr. Abel. This is really a thoughtful and a welcome presentation of some of the real problems in social security.

I talked the other night at the request of some steelworkers in Johnstown to those people, and I was appalled at the number of widows who were present in the audience, 40 or a little better.

I have a bill in here that would add the credits of a wife to the credits of a husband so that she could draw. And I draw your attention to the fact that those widows who are working are merely paying taxes in social security. They are never going to get anything from those taxes because they are going to draw against their husband's.

I was asked specifically to address this very large audience on some of the improvements I have suggested. I hope too that you consider it, because it would help those women wonderfully.

Mr. ABEL. You might be interested, Mrs. Griffiths, in our basic steel pensions now. We not only provide for early retirement after 30 years' service, irrespective of age, we also have a widow's and survivor's pension now under our program.

Mrs. GRIFFITHS. I hope that their husband and children get something too.

Mr. ABEL. That is the same thing.

Mrs. GRIFFITHS. That is far better than the Federal Government—

Mr. ABEL. That is one of the reasons we are concerned with this dropout problem, because we do have people now who are eligible to retire and who do retire. But under the present arrangements by the

time that they reach 65, they will have severely reduced their social security benefits.

Mrs. GRIFFITHS. It is really quite unfair, and the method of figuring it on replacement of wages is ridiculous. There are people who have paid in many, many times the amount of money and draw a smaller amount than those who have paid for a shorter time and draw larger amounts, which is terribly unfair.

I thank you again.

Mr. ABEL. Thank you.

Mr. BURKE. Are there any further questions?

We thank you very much, Mr. Abel. We appreciate your appearance here today and your testimony.

Mr. ABEL. Thank you.

Mr. BURKE. Our next witness is Dr. Cecil G. Sheps.

Is Dr. Sheps here?

We welcome you to the committee, Dr. Sheps, and you may proceed.

STATEMENT OF DR. CECIL G. SHEPS, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. SHEPS. Thank you, Mr. Chairman.

Mr. Chairman, I have a prepared statement which I would like to submit as a part of the record.

May I make a correction, please, of a clerical error, on the last page which provides a résumé of my own background and which describes me as having been both the general director of the Beth Israel Medical Center in New York and the Mount Sinai Medical School at the same time. This, even if any human being had been asked to undertake it, is an impossible task.

I was director of the Beth Israel Medical Center, but was at the same time, professor of community medicine in this new medical school.

Mr. BURKE. That correction will be noted. Of course, it impresses me that you have been at the Beth Israel Hospital in Boston. It is a fine institution.

Dr. SHEPS. Thank you, sir.

That reference to community medicine provides a useful and I think pertinent bridge for my remarks on behalf of the American Public Health Association.

This association has a membership of close to 24,000 people. The nature of the membership is, I think, interesting and relevant to your considerations, because it consists almost completely of a wide range of professional people, physicians, nurses, public health engineers, social workers, nutritionists, all of whom are brought together in this association by their common interest in protecting and restoring the health of the public.

What brings them together is the concern for the health of the country. The social security legislation has, of course, consistently been designed to improve the health and welfare of the community.

The general remarks that I would like to make while focused primarily on medicare and medicaid, will also have a relationship to some other elements that have been funded and supported by the social security legislation.

Let me say, first of all, Mr. Chairman, that the American Public Health Association believes that a tremendous amount of good has

been achieved by the medicare and medicaid legislation. Despite the difficulties and despite the defects, I think we tend to forget that a tremendous amount of good has been done. There are millions of old people in this country now who no longer are subject to the terror that confronted them before medicare when they had to contemplate the prospect which almost inevitably would face them of prohibitive medical bills.

So far as medicaid is concerned, you might be interested, Mr. Chairman, to know that the American Public Health Association which is having its annual meeting this week in Philadelphia heard a report by representatives of the Health Department of the City of New York which is of great interest. They pointed out that, despite the problems and acknowledged discrepancies of the medicaid legislation, many thousands of people got care who never would have gotten it before. People without glasses were enabled to see. People with foot problems stopped limping and those without teeth who couldn't bite were enabled to eat food properly because of funds that were made available through medicaid.

The problems that we see in the operation of medicare and medicaid are largely problems that stem from the defects in the medical care and health system that our country has. If these two pieces of legislation confine themselves as they do to the payment of bills and do not take a leading and responsible role in shaping the structure, focus, purpose and objective of the services that are being paid for and their quality, then the task that we have as a responsible government is not being fully carried out.

We endorse the various measures that have been undertaken, and are now being proposed and planned to increase the efficiency and make sure the quality is good. The Health Department of the City of New York, by the way, is the only major unit in the Nation that has taken a thoroughgoing evaluation of quality of performance. Much more of this needs to be done to make sure that the services that are being given are indeed the ones that are most needed and that the quality of the performance meets appropriate standards.

The medicare legislation pays for a major portion of the cost of providing medical care to people in the later years of their lives and these are people whose health problems are determined largely by what has happened to them in the years prior to the age of 65.

Medicaid is available primarily to women and children. Their general living conditions, their standard of living, their nutrition, their level of education—all of these factors of life have an influence on their health. And if one is restricted simply to the payment of bills for part of the services that influence their health, then, of course, one doesn't have quite the leverage one would want to have in a logical integrated system of protecting and restoring the health of people.

Our suggestion, therefore, is basically that in addition to the measures that are aimed at making the present operation of the legislation function more efficiently that it would be wise to look at the relevance of the objectives of the legislation and to look to ways of using the leverage of the billions of dollars that are being spent as a method of improving the system and its effectiveness.

A consideration of great importance, of course, is to give primacy to prevention, to the prevention of the onset of illnesses. We do know how to do a good bit of that, particularly amongst younger people. We

also can prevent the further development and progress of chronic diseases even though we may not know how to prevent their onset. This depends upon discovering diseases early, rather than waiting for the symptoms to become severe, and arranging for treatment which will diminish and control the disability.

Then, toward the other end of the spectrum, our medical care system is geared to institutionalizing people, and there is a great deal of evidence, Mr. Chairman, that when people are institutionalized, they tend to deteriorate physically, socially, and mentally. We simply do not have the service structure to keep them mobilized and provide community services so that they can remain in their homes with a little bit of help, to give them a kind of umbrella of care through services where they live. This would enable them to continue to function and without a doubt would mean that the total cost of care would be decreased because the institutionalization would, therefore, to a large extent, be prevented.

So the problem we face is the balance, the focus and emphasis in the services and institutions that we have available to protect and restore the health of people. This is what we mean by comprehensive care.

The social security legislation originally passed in 1935 laid the foundation for modern public health services in our communities and for services to children through the support of the children's bureau. It is our belief that further activities of this kind that are aimed at the population that needs to be served in terms of prevention and in terms of a better balance of services will in the end give us a much better return for the expenditure of the Federal dollar.

There are various ways of doing this. We need more research in how to improve the delivery system, not only the delivery system of medical care but environmental controls and all the other factors of life that we know have an influence upon the health of people. This is not simply a matter of doctors and nurses and hospitals. There is a great deal more involved. It is our belief that demonstrations should be fostered that would indicate what the gains are and what is involved in the kind of changes that would give us a better system.

I was very glad to hear Mr. Reuther in testimony earlier this morning talking about the reform of the health care system. He talked about this primarily in terms of prepayment and health insurance. I would like you to know, Mr. Chairman, that the American Public Health Association is on record as being in favor of the extension of the prepayment mechanism but we believe that that extension must be tied to changes in the system and its effectiveness.

One important point was raised by the Honorable Mr. Corman referred to this morning when he asked Mr. Reuther about the fee-for-service system. I would like to add to Mr. Reuther's comments by simply underscoring what he said. There is a great deal of evidence in this country, completely satisfactory to the people who have studied this matter as objective experts, that physicians can work extremely well in a system which compensates them for the nature and scope of the responsibility they undertake rather than making their income dependent upon the number of types of procedures they perform. It is significant that in the Kaiser Permanente plan to which Mr. Reuther referred, the hospitalization rate for the population that they look

after is on the average one-third that of a comparable population getting the same kind of coverage on a fee-for-service free-choice basis.

Mr. Chairman, if that were applied to the whole population it would represent a decrease in the total medical care bill of close to 10 percent.

When we examine the reasons for the difference in the hospitalization rate, we find that they are largely in the area of elective surgical procedures, surgical procedures of a kind in which there is room for latitude of judgment as to whether it is indicated. The removal of the uterus in middle-age women, tonsillectomy, and appendectomy happen to be conditions in which there is often room for discussion as to whether they really are indicated in individual cases. The fact that in one system that operation means several hundred dollars, and in another system doing that operation adds nothing to the income of the people who give service, makes it difficult to avoid the feeling that somehow the economic factor may play a part, even if subconsciously, in the thinking of those who are involved.

I am not suggesting, Mr. Chairman, that it is impossible to get good care under fee for service. What I am saying is that the evidence is very clear that personal health services can be provided very effectively by professional people whose payment is arrived at on another basis than the number of procedures they perform.

In closing, Mr. Chairman, I would say that the American Public Health Association feels very strongly that there are great achievements that can already be credited to the medicare and medicaid legislation, that the problems that we face the problems of the system, that it is inadequate to merely pay the bill that comes out of the present system, and that what needs to be done is to use these programs as a means to define goals that are much clearer and more specific in terms of the health services system. We need to convert the miscellany of services into programs of care which are designed to protect and restore the health of whatever section of the population we wish to serve.

Thank you very much.

(The prepared statement referred to follows:)

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION PRESENTED BY
CECIL G. SHEPS, M.D.

Despite many decades of experience with a complex variety of special programs, the health care of the American people still falls tragically short of its true potential. Standard measures of health compare unfavorably with those of other advanced nations, large segments of the population are deprived of adequate medical care, and wide discrepancies persist in the quality of available services.

The American Public Health Association assumes as its basic objective the promotion of the highest attainable health status for all Americans. While this requires an undiminishing, long-range effort, it is essential that immediate action be taken to overcome the most pressing current deficiencies in health care. Two channels for remedial action are recommended: revision of the "Medicaid" program and strengthening of the "Medicare" system.

Deficiencies of the Medicaid Program

The Social Security Amendments of 1965 were a beginning response to the public demand for improved health services. Unfortunately, these programs have not fulfilled the high expectations and purposes toward which they were originally directed.

Medicaid has been particularly inadequate in this respect. It has not only failed to correct existing deficiencies in the provision of medical care to the needy but has perpetuated and accentuated many of the most glaring inequities and indignities. Specifically, the Medicaid program has:

1. Continued the degrading and regressive system of charity medical care based on a means test, which is compounded by the obstacles it imposes to obtaining adequate medical care.

2. Aggravated the incoordination and fragmentation that have long existed among a complex variety of financing mechanisms and health services. New and difficult administrative problems have been added by the disparate mechanisms of the Medicare and Medicaid portions of the legislation.

3. Perpetuated a system of episodic and depersonalized medical services whose highly variable quality is generally below the potential of modern scientific medical care.

4. Accentuated the discrepancies among the various states in financial arrangements for medical care to the needy. While the richer states have been able to augment their medical care budgets for the indigent, many of the poorest states have been unable to supply matching funds and thus have achieved no involvement in the Medicaid program.

5. Failed to cover, even in those states with operating programs, all persons for whom medical care costs are a financial burden and a significant barrier to adequate care. Eligibility limits have frequently been set at levels so restrictive that they exclude not only the medically indigent but many of the totally indigent as well. Indeed, only a minority of the programs now established in the various states provide for the medically indigent, for whom the new legislation was specifically intended.

6. Failed to provide sufficient and realistic financing of certain elements of the medical care which it does cover, such as the costs of out-patient clinic and nursing home care. Reimbursement rates for these services have been keyed to outmoded welfare formulas with adverse effects on the amount, type and quality of care which is provided.

7. Created the paradoxical and highly inflammatory situation in which elevated public expectations coincide with retrenchment in the program. Grave hardship has been created in those service areas where items of health care based on the original intent of the legislation have been excluded from reimbursement through constriction in the operative scope of the program.

8. Perpetuated a system in which concern with payments takes precedence over such critical issues of health service as standards of quality, integration of resources, assessment of needs, emphasis on prevention, and the like.

Problems Associated with Medicare

Medicare, the health insurance program for the aged, shares some of this indictment, although its conceptual and programmatic contributions to an improved health service system for the nation must be commended. Especially important in the Medicare program are the utilization of the social insurance mechanism of financing and the promotion of the basic concept of requiring quality standards in the provisions of publicly financed services. Serious problems persist, however, with respect to the perpetuation of uncoordinated and incomplete patterns of delivering medical care. Major concerns in this regard should be mentioned:

1. Overemphasis on institutional and custodial forms of care for the aged to the neglect of prevention of the complicated stages of illness, protection of function, and rehabilitation.

2. Failure to require consistently high standards of quality in all the professional, technical and institutional services provided.

3. Persistence of financial barriers to needed medical care. Deterrent mechanisms, such as coinsurance and deductibles and self-insurance for physicians services, have created serious hardship for those who can least afford even basic health care.

4. Perpetuation of administrative redundancy and inefficiency by maintaining separate financing and eligibility mechanisms in the two parts of Title XVIII—the compulsory social insurance system for hospital and extended care facility benefits (Part A) and the publicly subsidized voluntary insurance method for physician services (Part B).

5. Persistence of an uncoordinated administrative pattern through the fragmentation of operational responsibility among national and regional offices of the Social Security Administration, federal and state public health agencies, and nongovernmental local agencies.

Strengthening of the Current Programs

In view of these serious shortcomings, the time has come for revision of Medicaid and Medicare in order to align them with their original purposes and

potential. It would be tragic if, having launched programs intended to remedy critical deficiencies, the net effect were the permanent entrenchment of these very defects. Basic principles underlying such revision are:

1. Eligibility criteria must be established which eliminate use of the means test as a prerequisite for qualification. One example is the recently developed "declaration method" of the Social and Rehabilitation Service, in which the statement of the applicant is accepted as a basis for eligibility, with provision for evaluating the accuracy of eligibility determinations through subsequent review of sample populations.

2. Reasonable standards for the quality of care must be assured throughout both programs. This requires deliberate, administrative promotion of quality by establishing operational standards, control procedures and structural changes in the methods of providing care. Responsibility for insuring the maintenance of such standards must be assumed by those agencies empowered to distribute public funds.

3. Uniformity of coverage throughout the country should be assured to those eligible for federal or federally assisted programs. Methods must be established which overcome the inequities among state and local resources for financing health care.

4. A stable mechanism for funding is needed, based on a realistic assessment of costs, which will allow adjustment for expanding costs without curtailment of eligibility or benefits. This goal requires the Federal Government to be the major source of funds for providing adequate health service to disadvantaged groups such as the aged and medically indigent.

5. Administrative responsibility must be placed at the appropriate level. Health service programs involve more than financing mechanisms; responsibility for the quality and quantity of care provided requires the professional expertise of agencies knowledgeable about and devoted to health care. Furthermore, administration must be at a level of government which assures awareness of and staunch commitment to local needs while permitting the greatest efficiency of operation.

6. Reasonable and realistic levels of payment for care must be assured. The concept of cheap services for poor patients, with all it implies in terms of low quality and degrading conditions, must be eliminated once and for all in the United States.

Specific Revisions for the Medicaid Program

Medicaid should be modified and expanded in the following ways:

1. Effective incentives for the various states must be developed to achieve and maintain uniform national coverage. Revision of current matching formulas with increased federal financial participation, especially for the poorer states, is a minimum requirement.

2. There must be commitment of strong federal leadership to develop and implement the framework, already present in legislation, for the establishment of high-quality performance standards for the providers of health services. This should reflect the concept of a coordinated health system which utilizes a variety of health services, including community health centers, medical group practice units, and other organizational innovations.

3. Reasonable and nationally consistent criteria of eligibility for benefits under the program must be established at levels which permit adequate coverage for the medically indigent, and with firm assurance that these levels will be maintained.

4. It should be required that administrative responsibility for the program be located in federal and state departments whose primary mission concerns the provision of health services.

5. The scope of benefits should be expanded to make truly comprehensive medical care available to all who are eligible.

6. A data retrieval system should be instituted which will be capable of revealing performance trends in various types of services and of identifying providers of care who deviate significantly from norms of quality and cost.

Strengthening of the Medicare Program

Medicare should be modified in the following ways:

1. The separate financing of physician services through the mechanism of voluntary insurance in Part B should be eliminated. This element of medical care costs could be adequately covered under the required contributory mechanism of Part A.

2. Mechanisms which were designed as deterrents to early utilization, such as coinsurance and deductibles, should be completely eliminated.

3. Coverage for medical care benefits should be broadened to embrace the categories of "Disabled and Survivors," whose inclusion as beneficiaries of the Social Security system antedates the Titles XVII and XIX health care amendments.

4. The limit on the duration of extended care services should be removed.

5. The scope of benefits should be expanded to include coverage for costs of prescribed and specified drugs, preventive and early care services including screening and diagnostic procedures; and truly comprehensive home care including home maker services when required for medical reasons.

6. Stimulation of more effective patterns of organization, such as incentives to group practice and liaison arrangements between various institutional providers of service, should be built into the program.

Manpower Utilization and Development

It is obvious that comprehensive medical services of good quality cannot be provided to the American population unless the supply and distribution of trained manpower are commensurate with the scope and standards of the proposed programs. At the same time, determining the needed quantity and variety of these resources depends upon removing all barriers to necessary care and upon substituting efficient methods of organizing health services for the present uncoordinated patterns. It must be recognized that solutions to the problems of providing adequate financing and efficient organization of health services are inseparable from those of generating sufficient health manpower. A deliberate and intensive program to develop adequate numbers of health personnel and to discover and implement more efficient patterns of employing them must be a concomitant of the above revisions.

Conclusions

The recommendations herewith presented would initiate an orderly, logical and cohesive advance from the present disjointed pattern of American health services to a comprehensive and democratic national system of high quality. This involves an honest recognition of present deficiencies. On such basis the proposals call for immediate revision of the existing program of medical services for the indigent and medically indigent (medicaid) and significant modification in the program of health insurance for the aged (Medicare). The American Public Health Association expresses its firm conviction that the United States can undertake nothing less as a minimal basis for progress toward the goal of proper health care for all Americans.

BRIEF RÉSUMÉ OF PERTINENT FACTS RELATIVE TO CECIL G. SHEPS, MD.

Presently Director, Health Services Research Center and Professor of Social Medicine, University of North Carolina, Chapel Hill, North Carolina.

Formal Qualifications

M.D.—University of Manitoba

M.P.H.—Yale University

Summary of Experience

General Hospital (internship, assistant residency, etc.) 3 years

General Practice (urban and rural) 4 years

Medical Administration—Preventive Medicine and Public Health, 26 years

Evidence of Qualification

Board of Directors and Past Vice President, National Council on Aging

General Director, Beth Israel Hospital, Boston, Mass., 1953–1960

General Director, Beth Israel Medical Center and Professor of Community Medicine, Mount Sinai Medical School, 1965–1969

Of particular pertinency was Dr. Sheps' service from 1964–1967 as Consultant on Medical Affairs to the Commissioner of the Welfare Administration. This occurred during the inception of the Title XIX (Medicaid) program.

(Full curriculum vitae available upon request.)

Mr. BURKE. Thank you, Dr. Sheps. Your entire statement will appear, without objection, in the record.

Are there any questions?

Mr. CORMAN?

Mr. CORMAN. I was rather surprised at how low we stand on the mortality table according to the WHO figures. Are there any other industrialized nations that deliver medical service solely on the fee for service basis as we do?

Dr. SHEPS. Oh, yes.

Mr. CORMAN. What other nations rely on that?

Dr. SHEPS. I'd like to correct my reply. I don't know, sir; whether it is solely a fee for service anywhere. In our case, for example, there are exceptions.

Mr. CORMAN. With some very minor exceptions, I take it the indigent get some medical care other than a fee for service.

Dr. SHEPS. Yes. The Kaiser Permanente kind of program now covers, if you include HIP in New York, close to 3 million people so that one and a-half percent of our population has its medical care paid for in another way and I suggest to you, sir, that this is no longer an experiment. That is a large sample when you have 3 million people.

However, to go back to your question, sir, in the Scandinavian countries, for example, many of the western European countries, the health insurance system does pay fee for service to the practitioner. In many of them, however, the fees are according to a schedule and not on the basis that we have used in the medicare program here.

Mr. CORMAN. But you couple the compulsory medical insurance with a fixed fee schedule in those countries, is that correct?

Dr. SHEPS. That is what happens in most of those countries. If I may add another kind of response, sir, I think that it is important to recognize that mortality rates can indeed be influenced by medical care but they are also influenced by other factors in the level of living: Where a man is born, where he goes to school, how much schooling he has had, the kind of job he has had, whether he smokes cigarettes or not, whether he lives in a polluted atmosphere or not, also has an important influence on his health.

Mr. CONABLE. Mr. Chairman?

Mr. BURKE. Mr. Conable.

Mr. CONABLE. I understand the general thrust of your testimony, sir, and I understand about the problem on fees for medical procedures, the incentives that are involved there. I am wondering if we don't run some risk, however, of underdiagnosing when we start giving the incentives for not treating patients.

Dr. SHEPS. That is a very pertinent question, and I think the answer to that can be given in various ways. In the first place, the evidence from these programs to which reference has been made is that the quality of performance there is good and acceptable.

Second, a very important part of any program is the monitoring function, the setting of goals, and this needs to be done in all types of programs, and I think this is the kind of guarantee we need to have.

We can set forth very direct expectations of the kinds of things that need to be done. That is predictable and can be monitored.

Mr. CONABLE. We have to avoid the assumption that the only thing bearing on illness is medical care.

Dr. SHEPS. That is right.

Mr. CONABLE. Because illness can result from any number of degenerative factors not related to the type of care that a person has been getting. Therefore, we do have some problems in the monitoring process.

Dr. SHEPS. This is precisely so and it is the American Public Health Association which feels very strongly that this balance needs to be recognized and that there might indeed be a time when one might need to make a choice between drastically improving the atmosphere that people breathe or adding another benefit to the medical care program itself.

Mr. CONABLE. The problem in this is going to ultimately be in the administration of the program, actually, because although you can give a basic thrust to your program by whether you treat illness or whether you prevent illness, a great deal will depend on how the program is administered.

Dr. SHEPS. Precisely.

Mr. CONABLE. So simply addressing the general goals isn't really going to be a very large part of the answer, is it?

Dr. SHEPS. Well, that is true, but what I was trying to say was that if the purpose of the legislation is simply to pay the bills when they are incurred then there is no opportunity to do any of the things that we have been discussing.

Mr. CONABLE. Yes.

Dr. SHEPS. Therefore, one needs to direct the legislation at goals that are really quite specific, giving recognition to the range of factors that influence the health of people.

Mr. CONABLE. I think, however, in the administration of any medical program we are going to have to root it ultimately in a large degree of control on the part of the patient as well as the doctor. The doctor, again, is not the only factor involved.

Dr. SHEPS. That is true, plus, I would suggest the kind of community services that are available. If a patient 70 years of age spends 20 days in a hospital and then he goes to an extended care unit and then he still needs some service and he could go home if he had a visiting nurse come in three times a week and that program isn't available, then he doesn't go home.

And we believe, for example, that the utilization reviews which are required in the medicare legislation can be used as a diagnostic measure to determine what the community needs. The general experience is that very often patients are kept in the hospital because the smaller group of services that they need, which if available at home would enable them to go home, are just not available. Our system is not geared to give that emphasis because what our communities have been taught to pay attention to is the number of hospital beds, the dramatic aspects of care, and, therefore, as you imply, sir, we would agree with you that whatever is done by way of payment and in the relationships of the administration of the program to the other community services that influence the health of the people, must become a totality in some organized functional way.

Mr. CONABLE. Thank you very much.

That is all, Mr. Chairman.

Mr. BURKE. Thank you, Dr. Sheps. The committee appreciates your testimony.

Dr. SHEPS. Thank you.

(The following letter and resolution were received by the committee:)

THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,
Washington, D.C., November 21, 1969.

HON. WILBUR MILLS,
Chairman, House Committee on Ways and Means,
U.S. Capitol, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed please find a copy of a resolution adopted unanimously by the Governing Council of the American Public Health Association at its 79th Annual meeting on November 13, 1969 in Philadelphia. The Association views this matter with great concern and respectfully asks that you include this material in the record of your recent hearings on amendments to the Social Security Act. Would you also be kind enough to bring it to the attention of your colleagues on your committee.

Yours truly,

BERWYN F. MATTISON, M.D., *Executive Director.*

CHIROPRACTIC AND NATUROPATHY

Chiropractors are licensed to practice throughout the United States (except in Louisiana and Mississippi). Naturopaths are also licensed in at least six States and the District of Columbia. These practitioners provide primary health care to a segment of our population, treating a wide range of diseases and conditions, including infectious diseases, heart conditions, and cancer, along with the musculoskeletal conditions for which they are commonly known and which are believed to be the major part of their practice.

The Department of Health, Education, and Welfare, at the instruction of Congress, recently conducted an intensive study of these two professions. On the basis of its findings, which are fully documented in the report, the Department concluded that:

Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic and naturopathic services not be covered in the Medicare program. (The same language was used for naturopathy.)

It appears that the practice of chiropractic and naturopathy constitutes a hazard to the health and safety of our citizens. The American Public Health Association therefore urges:

1. That Congress amend Title XIX of the Social Security Act to specify that Federal funds not be used to match State Medicaid expenditures for chiropractic or naturopathic services.
2. That Congress not amend Title XVIII of the Social Security Act to permit coverage of chiropractic or naturopathic services in the Medicare program.
3. That State legislatures and health agencies not include chiropractors and naturopaths under State health programs.
4. That States reevaluate their existing licensure programs for chiropractors and naturopaths to determine whether such licenses should be further restricted or abolished, and that existing restrictions be more rigorously policed.
5. That professional and consumer groups undertake appropriate consumer education on the hazards of unscientific health care, including chiropractic and naturopathy.

Mr. BURKE. Our next witness is John Cosgrove.

Mr. Cosgrove?

I might say for the benefit of those who expect to testify here this afternoon, that the committee expects to adjourn approximately at 12:30 and then return here at 2 p.m., so if you wish to go out and get lunch it might be a good opportunity for you to do that now.

We welcome you to the committee, Mr. Cosgrove, and you may identify those associated with you and proceed.

STATEMENT OF JOHN E. COSGROVE, DIRECTOR, DEPARTMENT OF SOCIAL DEVELOPMENT, UNITED STATES CATHOLIC CONFERENCE; ACCOMPANIED BY MSGR. HAROLD MURRAY, DIRECTOR OF THE DEPARTMENT OF HEALTH AFFAIRS; AND FATHER CHARLES BURNS, ASSOCIATE EXECUTIVE SECRETARY OF THE NATIONAL URBAN TASK FORCE, AND DEPARTMENT OF SOCIAL DEVELOPMENT

Mr. COSGROVE. Thank you, Mr. Chairman.

I am John Cosgrove, Director of the Department of Social Development of the United States Catholic Conference. The U.S.C.C. is a coordinating agency for the American bishops within the Catholic Church. I am accompanied by Msgr. Harold Murray on my right, director of our Department of Health, and by Father Charles Burns on my left, the associate executive secretary of our National Urban Task Force.

We very much appreciate the opportunity to present our views to the committee. We would hope that the whole statement submitted might be part of the record, sir.

Mr. BURKE. Without objection, the entire statement will appear in the record.

Mr. COSGROVE. Thank you.

Our testimony this morning, and my oral remarks will attempt to cover only some of the highlights of H.R. 14173 and the general policies which we believe should guide a family security program and brief comments on H.R. 14080 and the questions of health needs.

The underlying intent of H.R. 14173 that a family assistance plan provide basic benefits to low income families with children replacing our present welfare system to dependent children we think is a good one and a sound one. The American bishops in a pastoral letter last year said, and to give a short quotation: "If families are to function as the good of society requires, each must have income proportionate to its needs."

H.R. 14173 represents in this area, we think, a new and realistic attempt to provide a basic income for poor families and it thereby merits and receives our endorsement and our support.

The attempt in the legislation, we think, is to maintain the family unity and we think it is directed toward helping the family unit function under its own power, which are basic considerations. The family, unfortunately, in the past has not always been considered as a specific social unit in the formulation of sound social policy. We think that this legislation represents a departure from that lack and a good departure. The welfare system that has existed has so many problems that probably they do not require elaboration here in the limited time. We think, though, that clearly a complete redirection and reorientation of the past program is necessary.

We believe the family assistance plan is a positive and workable alternative, and a start in what we hope is the first of a series of steps toward family centered policies by the Congress and by the Government.

The family assistance plan even as we endorse it would, however, sound a note of caution on some aspects. Specifically, the role of the

mother during the preschool years, we believe, is a critical factor for the healthy development of the child, the welfare of the family, and to provide that for a mother head of family whose children are six or over as a precondition to benefits she would have to register under the program proposal, we think is a mistake. It should be reconsidered very carefully.

We would urge in that instance the option be provided here as to whether or not she would proceed to training or employment. The basic problem reservation, I think, that we would express is with regard to the question of an adequate program, adequate level of benefit under this proposal. The patent inequity of a society as rich as ours failing to order its priorities to provide for the fundamental requirements of its members we suggest should require little elaboration.

What is needed broadly is a program to assure that each person, each family in the country, has an adequate annual income, either through employment or, where that is not proper or practical as a means, through an alternate method. As I say, we hope that this proposed act is a starting point though it does not do the job itself, starting point toward a fully adequate program of some guaranteed annual income that will be devised by the Congress.

The weakness of the present system probably adds emphasis to the important departures here and to the additional things that we suggest should be undertaken. Certainly in the subject legislation the commitment of the Federal Government to a larger responsibility for solution of the problem of a "lack of income adequate to sustain a decent level of life" is a forward step, even if not completely achieved here.

The declaration method of determining eligibility should eliminate the demeaning and wastefully detailed investigation by local welfare officials. The setting of a Federal floor on income is certainly a significant step forward. The addition of the working poor is, of course, highly desirable.

We think, however, there are aspects that tend to contradict the goal expressed in the President's message of August and in the bill. We would like to comment very briefly on a couple of these.

The first, and I alluded to this before, we would consider to be the inadequacy of the minimum amount provided. The basic payment of \$1,600 for a family of four is far too low where that is all they receive. It is less than half the amount used by the Government to define the poverty level. It barely meets the adequacy of the Government's definition of "poverty."

The proposed Federal minimum benefit level comes out to about \$30 per week per family, or less than \$8 per week per person. We think this is unconscionably low for a society that is probably the world's richest and will reach a Gross National Product of about one trillion dollars in the 1970's.

We think that the proposal of a minimum Federal benefit amount that fails to reach 50 percent of the most modest definition of the need is not sufficient. This is almost literally a half-measure on that aspect.

On the matter of work, which is a central aspect of this whole proposal in the President's message, the American people, I think it is clear, feel that the poor should work for a living if they are able. The evidence suggests that most of the poor people themselves agree with this. Most of the poor are poor because they are unemployed or work at jobs paying very low wages. Employment is a relevant answer to

poverty only if one is not too young, or old, or unskilled or too remote from jobs, or too ill, or to incapacitated or physically or psychologically handicapped and only if one can find a job with truly adequate pay.

In addition, there are related comments, Mr. Chairman, that we would like to make. We think that, while the employment factor is undoubtedly important, it is a positive or negative factor depending on how it is used. It is positive if joined with job opportunity, training, with enlarged opportunities for upgrading. It is important negatively if it is a club to harass the poor, a penalty to threaten the worker, or a tool to disqualify on grounds of dubious validity. The poor need no more watchmen or "guardians" to police their activities, but need a respect for their privacy and protection of their God-given dignity.

We would suggest that the central dangers to be avoided include training people for nonexistent jobs, or jobs paying so little as to keep them in poverty, that the proposed training program is curiously isolated from any job creation program. The unemployment rate, as you know, has been increasing recently and at 3.9 or 4 percent is disturbingly high. We would hope that in that context the attempt to cool off the inflationary problem in the economy would not be at the expense of the poor and workers by increased unemployment, and that this should be guarded against.

On the bill itself here, the disqualification of the family head for benefits which would follow the refusal to accept training or employment referral causes some problem. If one is referred to a job we understand the administration's position to be the referral of one to a job is a precondition for the family head's benefit. This is not to be construed as suitable employment. We understand the position to be if the job pays less than the applicable minimum wage or the prevailing wage, whichever is the higher. We suggest that if this is to be the practice, that "applicable" be defined as the Federal minimum wage whether or not in fact it would cover a particular job.

The history, I think, of analogous programs gives us some cause for concern, words and phrases that appear "for good cause" and "suitable employment" in referral to employment. The Employment Security Act since 1935, specifically the unemployment insurance program, has an unhappy history on this point. To be eligible for benefits, as you know, under the proposal, one would have to participate in suitable manpower services, training or employment, or not to have refused without good cause to accept suitable employment.

We note here that, while there would be Federal Cabinet Secretaries determining the definition of these standards, the referrals are by the State employment service. They would be referring people to the work thought to be suitable, and we would urge here that there should be some vigorously enforced Federal standards spelled out in the statute on referrals to be sure that there is an even-handed interpretation and equitable application on this point.

We suggest a workman might for good cause refuse employment if, for example, the job was far below the Federal minimum wage or the prevailing wage, whichever is higher, if the job was unusually hazardous, or a number of other circumstances that would come to mind.

What are our recommendations generally?

We propose that the provision requiring registration of mothers, as I alluded to earlier, be optional. We would suggest that again the value of the maternal presence in the home is very great indeed. In addition, we would suggest that the benefit level be something nearer what is adequate and that it should rise proportionately if the Consumer Price Index rises.

Our social accounting system, of course, makes it difficult to ascertain the cost of these matters of any family assistance as against, say, the costs of jails and mental institutions, and similar remedial preventive expenditures which do have some relation to poverty and to deprivation.

The problem of inflation alluded to before is one of continuing concern to us. We would hope that a program such as here under consideration could be part of a series of actions, for example, covering workers more broadly, more workers under unemployment insurance, specifically, for example, farmworkers, that one could work immediately and effectively against poverty and helping family security, family assistance, by the tried and proven methods of raising the minimum wage under the Fair Labor Standards Act, extending its coverage, raising the amount to perhaps \$2 an hour.

We consider that no welfare program will be sufficient unless it is accompanied by a job-creating program and the termination of racial discrimination in employment and housing, fully funding of our low income housing program, and renewed attention to urban problems, and the whole panoply of problems to which we have to address ourselves.

We would on a more basic level, perhaps, raise the question of whether this whole program of family assistance ought not to be wholly federally financed and federally administered with national standards throughout. Certainly this is one consideration that should be before the committee.

Having noted reservations, though, I want to repeat that we support the departures and the important innovations in the basic intent and concept of this bill.

I would like, Mr. Chairman, to note, also, as to H.R. 14080 that obviously a vital piece of the mosaic of the economic security is the Social Security Act. The 24 million recipients are an important part of the economy and most importantly are people that need this assistance for the most part. The minimum monthly benefit they now receive of \$82.50 for a couple or \$55 for an individual, we think is wholly inadequate. This minimum should be raised substantially at the earliest possible date.

H.R. 14080 calls for an increase of 10 percent. We suggest this is wholly insufficient. There should be, we think, at least a 15 percent overall rate of increase effective as soon as possible, particularly in view of the fact that from the last increase until the scheduled effective date of the one here proposed the cost of living could very well have increased by 10 percent or more, resulting in no real increase.

It is noteworthy, we think, that the bill, H.R. 14430, pending before this committee, I believe, would provide a 50-percent increase in total benefits over the next 2 years. We think that for that reason and

for its other provisions H.R. 14430 deserves some consideration and careful consideration by the committee.

A further purpose of this testimony today is to offer our support to the fine work of this committee and the Congress in developing a program of health care for elderly citizens. The medicare program has made, we think, enormous progress. This program should be continued and improved. We are concerned of course, about some aspects of it, for example, cost of health service, some attempt to control this. The shortage of health manpower is a serious problem. We urge the committee to do everything it can to assist in the training of additional personnel in the health field.

We particularly support the statement on the financial requirements of health care institutions and services of the American Hospital Association as a very practical mechanism to achieve this goal. We recognize that only through full participation and support of proper planning mechanisms can health care institutions continue to call for the financial support of government and private payers, and we support this committee's effort to insure that health care planning will serve its announced goals.

We fully support the pleas of the American Hospital Association to include all those under 65 under medicare. We hope this committee would make every effort to include payment for the drugs and other medications frequently required by older people on a life-sustaining basis and do this at the earliest possible date. Unaffordable drugs present a problem.

We would urge that there be support for payment of such drugs. We would further encourage this committee to direct its attention to ways of providing all forms of preventive health care to medicare beneficiaries and to ways of stimulating this coverage under other programs, private and public. There is, we think, strong evidence that preventive care is less expensive. We look forward, of course, and I am sure the committee does, to the time when all Americans would feel the security and enjoy the health benefits of adequate and affordable health care. We commend the efforts of this committee for helping to make that goal reality.

We would hope, Mr. Chairman, we could on some of these points as the time goes forward, and alternate proposals may appear on some of these points we mentioned today, have the opportunity to submit a further statement.

Thank you.

(The prepared statement referred to follows:)

STATEMENT OF JOHN E. COSGROVE, DIRECTOR, DEPARTMENT OF SOCIAL DEVELOPMENT,
UNITED STATES CATHOLIC CONFERENCE

I am John E. Cosgrove, Director of the Department of Social Development, United States Catholic Conference. The U.S.C.C. is an agency of the Catholic Bishops of the United States. Its purpose is to unify and coordinate activities of the Church in the United States in works of social development, health, education, immigration aid, civic education, communications and public affairs. I am accompanied by Monsignor Haarold Murray, Director of the Department of Health Affairs, and from our Department of Social Development, Father Charles Burns, Associate Executive Secretary of the National Urban Task Force. Both of these men have worked in aspects of this program. I appreciate the opportunity to present the views of our organization before this Committee.

While this committee is considering a variety of proposals related to welfare and family income, we will concentrate our testimony primarily on H.R. 14173 and the general policies which we believe should guide a family security program, on H.R. 14080 and the questions of health needs.

Recognizing that considerable testimony will be given the Committee on specific sections of the Bill, I wish to state at the outset that a primary focus of my remarks is the underlying intent of H.R. 14173, that is, the establishment of a Family Assistance Plan providing basic benefits to low-income families with children that will replace our present program of welfare assistance to dependent children.

One year ago, the National Conference of Catholic Bishops addressed itself to some of the problems confronting families in our nation in their pastoral letter, *Human Life in Our Day*. Pertinent to the question before us, the bishops noted:

Informed social critics are asserting that family instability in the urban areas of America is the result, in part at least, of our national failure to adopt comprehensive and realistic family-centered policies during the course of this century. The breakdown of the family has intrinsic causes, some of them moral, but these have been aggravated by the indifference or neglect of society and by the consequences of poverty and racist attitudes. The object of wise social policy is not only the physical well-being of persons but their emotional stability and moral growth, not as individuals but, whenever possible within family units.

Let me also note that in the aforementioned pastoral letter the Bishops state that "if families are to function as the good of society requires, each must have income proportionate to its needs." The pastoral went on to note that in our country, "income is often based on the work done, plus productivity." The man with a family draws the same income as the single person, despite the difference in responsibilities. The bishops went on to state that "the effective solution we are urging may well require a family allowance system. . . . We stand ready to support enlightened legislation in this area."

The Family Assistance Plan authorized by H.R. 14173 represents a new and realistic attempt to provide a basic income for poor families, and thereby merits our endorsement and support. It maintains family unity and is directed toward helping the family unit function under its own power, thereby insuring stability and cohesion, while at the same time it contains incentives for job training and employment for the head of the family. The effects of this employment incentive should not be overlooked. To build a financial base, a person needs a job. To obtain a job in our society, a person needs training. Job training and employment opportunity for the family head help the poor family acquire a source of steady income, and it also helps the head of the family achieve a sense of self-worth and achievement. Too many Americans, freed from the conditions of poverty and family instability, are socially myopic in their conviction that poor families choose the welfare system in preference to working for a living.

Theoretically, the importance of family stability to the good of society has always been recognized, but the family itself has not always been considered as a specific social unit in the formulation of sound social policy. Conversely, we have long realized that poverty is often the result of family breakdown, and the instability of many families is at least partially due to our failure to adopt comprehensive and realistic family-centered policies in an effort to eliminate poverty. Some of our welfare policies led to the disruption of the family unit, such as the provision that financial assistance would not be granted to a family in which there was an able-bodied father; or the requirement that mothers of young children must work or take job training as a *condition* for receiving welfare assistance. The diversity of standards and the difficulties of administering our present system often provided greater income to those who did not work than to many who struggled to maintain some type of employment. It wasn't the poor who were at fault, nor only those who were shrewd at beating the system; to some degree we are all at fault because we realized the inadequacy of the welfare system, but we have been unwilling to take the risk of a new approach and to commit ourselves to an increased investment.

In recent years, there has been a growing realization that our welfare system was beyond the help of a series of well-intentioned amendments, and that a drastic overhaul was now in order. In fact, some experiments were already underway as of 1968. In New York, Teamsters Local #327 demanded a \$5.00 weekly allowance for each child in the member's family as part of the contract for employees of The City Housing Authority. In Trenton, New Jersey, 80 poor

families were engaged in an experiment with negative income tax which provided \$3,300 per year for a family of four that had no other income.

We might add to this the urging of social and political scientists in their scholarly journals, recommending a variety of alternate approaches that would center on providing income to the family unit instead of assistance to individuals who fall within specifically defined welfare categories.

Finally, on August 8, 1969, President Nixon proposed the long-awaited revision of the welfare system in his message to the American people. His proposals covered a wide range of topics, but there was general agreement that the Family Assistance Plan was a positive and workable alternative to our previous welfare system.

H.R. 14173 is important then, not only because it is an alternative to a welfare system that has become increasingly cumbersome and inefficient, but because it is the first step toward a series of family-centered policies that will benefit not only the poor, but all other portions of our society as well. Modern technology is quickly transforming social conditions and our ability to accumulate, store and utilize banks of information now places us in a most advantageous position for planning the future. At the same time, we are well aware that the social policies of a modern industrial nation cannot help but affect family life.

We now have to determine whether these will be purposeful policies that are directed to supporting family stability, or haphazard, ad hoc policies that create more problems than they solve. H.R. 14173 is an example of purposefulness that is in open contrast to the annual patching up of the welfare system. But in the face of continuing and dramatic social change that generates a corresponding challenge to the most stable of our institutions, the future of the family itself is frequently called into question. In a perceptive article on "Government Policy and the Family,"¹ Nathan Cohen and Maurice F. Connery point to the relationship of government policy and family stability.

We suspect that a revitalization of the family represents a neglected opportunity in the resolution of this crisis. As an institution, it has demonstrated a remarkable resilience and a capacity to adapt to a wide range of circumstances. It has provided a transitional experience for the individual that has linked past, present, and future. It has been a major source of cultural innovation and has proved its worth in the most simple and complex societies. Studies of values and attitudes have persistently demonstrated that the family is the primary source of both our individual and collective orientations and that this institution must be engaged if we are to achieve a lasting modification of values. The problems that confront the United States in the present day are problems that basically demand a radical shift in our values. As we move towards the solution of our problems, it is almost inevitable that we will make many false starts or that the transition to new patterns of society will create new stresses. The family, among all of our institutions, is uniquely equipped to cushion these shocks and to ease the strains that are an inevitable consequence of change. Yet if the family is to fulfill this need, it must be restored to a central place in our perception of the nature of our society and provided with the resources which will make possible the fulfillment of this role. This can only be accomplished by a major shift in government policy and action with respect to the family.

Granting a general endorsement of the Family Assistance Plan, a note of caution must be sounded in regard to employment of mothers of young children. The evidence now indicates that the role of the mother during the pre-school years is a critical factor for the healthy development of the child. Although H.R. 14173 does not require that she take employment, it certainly urges it in a strong fashion. The corollary emphasis on day care increases this pressure. It would be better to increase financial assistance to the mother of the young child than to accustom her to a role that separates her from her child or that places low priority on her maternal functions.

To again quote from the Bishops' 1968 pastoral letter:

The challenges and threats to contemporary family life may often seem insuperable. However, the resources of this nation are more than sufficient to enhance the security and prosperity of our families at home while leaving us free to fulfill our duties in charity and justice abroad. The scientific, educational and financial resources of our nation cannot be better utilized than in defense and development of the family.

These are some of the considerations we hope you will address.

¹ Cf. *Journal of Marriage and the Family*, Vol. 29, No. 1, Feb. 1967.

PRESENT SYSTEM

The weaknesses of the present system have been thoroughly exposed. Suffice to say here, the system requires a thorough reconstruction and redirection. The problem of economic opportunity and security is so complex that we would hope to be able to submit a further statement on specific aspects of the proposal at a later time.

The patent inequity of a society as rich as ours failing to order its priorities to provide for the fundamental requirements of its members should require little elaboration. We suggest that each member of a national or local community has some responsibility for and should feel some sense of solidarity with, all the other members. A particular obligation rests on the more fortunate to help those not so fortunate. The question is the degree of responsibility and the way to meet it best.

What is needed is a program to assure that each person, each family in the country has an adequate annual income, either through employment or, where that is not a proper or practical means, through an alternate method. This goal, a system of adequate guaranteed annual income, which could be achieved through other programs or a combination of programs, we submit, is both desirable "to promote the general welfare" and feasible in the near future.

As desirable as is the central purpose of the proposed Act, we view it as a starting point toward a fully adequate program of guaranteed annual income, which, of course, the proposed program is not.

We think there is substantial merit in both President Nixon's message of August 8, 1969, to the Congress and in the Administration Bill; and we strongly endorse the underlying intent, i.e., aid to low-income families with children, replacing our present A.F.D.C. The weaknesses of the present system have been thoroughly exposed but they deserve brief comment.

PRESENT PROGRAM

Possibly the chief weaknesses of the present welfare program, as it has evolved are:

(1) It fails to lift families with children out of poverty and penalizes efforts by the beneficiaries to accomplish this. Because of the inadequate benefit amounts, \$10.00 per person per month in Mississippi, with more in richer, more liberal states (where living costs are also higher), the payments fail to do the job.

(2) In about half the states there is no payment to families which have an unemployed parent at home, regardless of need, so that it often is economically "better" for the father to desert the family.

(3) There is now no Federal program of support for families where the father is working full time but is earning insufficient income to support the family.

(4) The present program is expensive, and increasingly so, particularly weighed on a cost/benefit scale.

ADDITIONAL STRENGTHS OF THE PROPOSAL

As we have noted in some detail, we subscribe to the basic thrust of the family assistance proposal. In addition, the supplemental Food Stamp Program will be available; this is good and perhaps it should be increased. The financial incentives to training, by training allowance and travel aid are helpful. The commitment of the Federal Government to a larger responsibility for solution of the problem of "lack of income adequate to sustain a decent level of life" is a forward step, even if the goal might not be completely achieved by the Bill.

The declaration method of determining eligibility should eliminate the demeaning and wastefully detailed investigation by local welfare officials. The setting of a Federal floor on income is significant. The equitable treatment afforded male and female heads of families is a needed change.

H.R. 14173 will provide Federal income supplements to an estimated 1.8 million families, in which the family head is employed at below poverty wages. Nearly all of these families are not now eligible for welfare benefits. The addition of this group, the working poor, is highly desirable. For the first time, this nation would have a clear policy of Federal responsibility for financial support for the family unit where the father is present and working.

WEAKNESSES OF THE PROPOSAL

Benefits and amounts.—As important and beneficial as are several of the central features of the Administration proposal, other features tend to contradict the goal expressed in the President's message of August and in the bill. H.R. 14173's Findings and Declaration of Proposed (Title IV, Sec. 2, (a) (4) note the chief welfare problems and includes the following statement:

In the light of the harm to individual and family development and well-being caused by lack of income adequate to sustain a decent level of life, and the consequent damage to the human resources of the entire nation, the Federal Government has a positive interest and responsibility in assuring the correction of these problems.

One of the chief purposes, then, of the proposed Family Assistance Program is to assure an adequate income. However, in at least some states, the levels of family assistance in fact proposed—though an improvement for some—will not do this. In the interest of improving the proposal, we suggest careful consideration of this elemental point.

A basic \$1,600 payment for a family of four is far too low, where that is all they receive. It is less than half the amount used by the Government to define the "poverty" level. Even the beneficiary family whose head earns over \$60.00 monthly with the family payment reduced by \$1.00 for each additional \$2.00 earned—a good idea in principle—would have all benefits cease when income reaches some \$3,920.00, slightly above the current poverty level. This proposal barely meets the test of adequacy, by the Government's own definition of "poverty." As the 1968 pastoral letter of the Catholic Bishops observed: "... if families are to function as the good of society requires, each must have income proportionate to its need." The question of adequate levels is always changing and so should be continuously reviewed.

The proposed Federal minimum benefit level—which is all that some of the people will receive—\$1,600 a year for a 4-member family, is some \$30.00 per week per family, or less than \$8.00 per week per person. This is unconscionably low for a society which is probably the richest the world has known, and whose annual Gross National Product will exceed \$1 trillion in the 1970s.

The Government has defined poverty; it has proposed a Congressional declaration that the nation has a responsibility to meet the problem of inadequate income; it has proposed a minimum Federal benefit amount which fails to reach 50 percent of the most modest definition of the need. At minimum, where the family head does not work, this is almost literally, a "half-measure."

In addition to the inadequate benefit amount there is a question of whether the level of funding by the national government should not be raised. Some states and municipalities are virtually unable to meet the rising welfare costs and may need more help than this bill provides.

Work, registration and training.—Most Americans feel that the poor should work for a living if they are able. Most of the poor themselves, by the record, agree. The great majority of the under-employed and unemployed seek the dignity of productive work. In fact, perhaps contrary to the popular conception, less than 100,000 able-bodied men are now on nation's welfare rolls. Most of the poor are "poor" because they are unemployed or work at jobs paying very low wages. Most of the poor in America are members of families whose head is employed. Thus, while the opportunity and training for work is important, it can be overstressed in relation to the reality. Employment is a relevant answer to poverty only if one is not too young, or old, or unskilled or too remote from the jobs, or too ill or too incapacitated or physically or psychologically handicapped and only if one can find a job with truly adequate pay.

We feel that there are related considerations which deserve comment, which may be covered in other legislation.

Even in proper perspective, employment is undoubtedly important. It is important as a positive factor if it is joined to practical training, enlarge opportunities (more jobs) and an upgrading of earned income. It is important negatively if it is a club to harass the poor, a penalty to threaten the worker, or a tool to disqualify on grounds of dubious validity varying from state to state. The work training and work requirement pre-conditions are acceptable if we can be assured that their possible use to disqualify for benefits is carefully circumscribed. The poor need no more watchmen or "guardians" to police their

activities. They need a respect for their privacy, a protection of their God-given dignity.

Those not required to register for employment or training, including wives of family heads, female-family heads with children under age 6, family heads who are ill, aged or disabled, children and those working full time. They are exempted from the requirement. The Administration estimated that of the 6.6 million persons in families presently receiving A.F.D.C., only something over one million would have to register. These exclusions are good. They underscore the reality, that new work/training programs are not the decisive correctives in attacking poverty though they are a factor in meeting unemployment. The decisive factor in poverty is need and the public action necessary to meet it.

The central dangers to be avoided include, we suggest: training people for non-existent jobs and training for, and referral of people to, jobs paying so little as to keep them in poverty while granting a human subsidy to marginal enterprises.

The proposed training program is curiously isolated from any job creation program. Obviously, the chief reason people are unemployed is that they have not found jobs. Our unemployment rate is increasing, as an incident to the anti-inflation program of "cooling" the economy. For what jobs is it proposed that the welfare recipient be trained? Is there a safeguard that one would not be referred to a job paying below the national minimum wage? While it is desirable that registered beneficiaries accept truly suitable employment or training, when they are reasonably able to do so, disqualifications should follow refusal to do so only where the employment offered is genuinely suitable or the training clearly relevant.

I understand the Administration's position to be that one referred to a job would not have to accept it (lest he lose his benefits) if the job paid less than the applicable minimum wage or the prevailing wage, whichever is higher. We suggest that "applicable" be defined as the Federal minimum wage, whether or not in fact it covers a particular job, if this is to be the practice. If this is made clear in the Act, in the legislative history and in application, it will be a strong plus for the program, for the poor and for the nation's economy. If these do not conjoin, the referral system will either disqualify large numbers or create a source of cheap labor, degrading the poor, subsidizing the marginal or ineffective employer and proving counterproductive. This is a central point.

The history of analogous programs give us cause for concern. The Employment Security Program, since 1935, has not had a happy record on this point. Its unemployment insurance program typically requires an applicant to accept a job unless he quits "for good cause" or for "good cause attributable to his employer," or if he refuses to accept "suitable employment." This has been abused in practice. The "good cause" norm now reappears in Section 448 of H.R. 14173, providing that to be eligible for benefits an individual who has registered must not have ". . . refused without good cause to participate in suitable manpower services, training or employment, or to have refused without good cause to accept suitable employment. . . ." if the employment offered is ". . . a bona fide offer of employment." While the registration will be with the local public employment office of the state, the failure to register "without good cause" will be determined by the Department of Health, Education and Welfare. However, it is the State Employment Service which will be referring the applicants to the work thought to be "suitable."

The history of administrative findings and judicial determinations show the varying and, in too many cases, unjust decisions which have resulted from these words and phrases when used in previous legislation. The liberal administration of these provisions will be vitally important if they are not to be used to drive people from the qualified roles. It is essential that there be strong, vigorously-enforced Federal standards on referrals to insure even-handed interpretation and equitable application of these requirements.

A workman has good cause to refuse employment, in our judgment, if, for example, the offer is of a job below the Federal minimum wage or the prevailing wage, whichever is higher, if it is an unusually hazardous job, if the commuting time is unreasonable, or if experience shows that the prospective employer consistently discriminates in hiring or up-grading on the basis of race, creed or color. Obviously an employer involved in a strike is not a "suitable" employer while the dispute continues.

Unless the statute, the legislative intent and the regulations are crystal clear, the abuse of this section can vitiate much of what the bill would otherwise accomplish. We are not satisfied that the bill now is adequate on this score. There should be explicit Federal statutory standards for work referral, minimum wages to be paid and "suitability" of employment offered.

RECOMMENDATIONS

For the most part, to here, we have commended or taken exception to various of the chief proposals with only one or two alternate suggestions. It can be fairly asked: what else is proposed?

We propose that the provision requiring registration of mothers of children age six or over—where heads of families—be optional as long as they have school-age children in the home. While many of the mothers who are heads of families and have pre-school children will desire to register, train and seek employment, this should not be a pre-condition to benefits. The value of the maternal presence in the home, for school-age children, is important, morally and socially. She should have an option on this point.

We suggest that the benefit level in the family assistance program, could be increased to an adequate level and still be economically and legislatively feasible. It should rise proportionately if the Consumer Price Index rises.

Everyone is concerned about the cost of the program. We suggest—as H.R. 14173 may well recognize—that it is more an investment than a cost; an investment in human resource and development. Our social accounting system makes it difficult to balance the outlay for family assistance against the costs of jails and mental institutions, and similar remedial and preventive expenditures which have some relation to poverty and deprivation. It is even more difficult to ascribe a dollar value to the human suffering and want, the indignity that could be obviated; we know, however, that these values are great.

The overriding moral imperatives in this question suggests we should look to reordering our national priorities.

We recommend that great care be taken that the problem of inflation be met by expansion of the economy, by an increased supply of goods and services, and not be asking the worker and the poor to carry the brunt by increased unemployment. The September rate of 4% unemployment, up 0.5 percent in a single month, gives cause for concern. The October figure of 3.9 percent is not reassuring.

We recommend, as part of an overall family economic security that coverage of unemployment insurance to be expanded, to include many others and specifically farm workers.

An immediately effective means of lessening poverty, a tried and proven method, would be to raise the minimum wage, under the Fair Labor Standards Act, to \$2.00 an hour and extend its coverage. Millions of Americans could be raised from poverty by this action alone. A wage of \$80.00 for a 40-hour week is minimal at this point in history.

We consider no welfare program sufficient unless accompanied by a job-creating program, the end of racial discrimination in employment and housing, a fully-funded low income housing program and a renewed attention to urban problems. Most of these, we appreciate, are beyond the scope of this hearing but they must be noted to complete the picture of a family economic security program.

Finally, we would raise the serious question of whether the program should not be wholly Federally-financed and Federally administered with national standards. The problem, like our mobile labor force and our economy itself, is national. It may be that it cannot be met by 50 programs but only by a national program of economic security.

Economic security and welfare are not the exclusive responsibility in this Federal Republic of the Federal Government—as is inter-state commerce—or the state government—as is ordinary crime detection. Instead either or both can function to alleviate want. Accordingly, the question is presented whether it would not avoid most of the problems if the Congress enacted a straight Federal program. The Federal government has greater tax resources and generally a more efficient and fair tax system. The patchwork system may be too costly in human terms. We suggest the Committee consider this. If the present proposals do not result in substantial progress toward ending human want, we will surely come to this question in the very near future.

We appreciate the opportunity to have presented our views relating to H.R. 14173 to this distinguished Committee and hope to be able to supplement them as the discussion of the proposals develops in the weeks ahead.

In summary, we have raised serious questions about H.R. 14173 and we hope these will be carefully considered. In net, however, because of its new commitment to family assistance, as such, we support the basic content of this legislation. We are for its basic thrust and trust that it will be strengthened and improved further by Congressional action.

O.A.S.D.I. AMENDMENTS

A vital piece of the mosaic of economic security is, of course, the Social Security Program of Old Age, Survivors' and Disability Insurance. We are, accordingly, pleased to testify on H.R. 14080.

For many of the more than 24 million recipients of Social Security benefits, it is a major—or even sole—source of income. Accordingly, the benefit amount, particularly the minimum, must be sufficient.

The minimum monthly benefit is now \$82.50 for a couple and \$55.00 for an individual. The beneficiaries at the minimum level, generally, have been able to amass few other resources or sources of income; hence, the importance of an adequate floor. The minimum should be raised very substantially at the earliest possible date.

H.R. 14080 calls for an increase of 10%. This is wholly insufficient. This is particularly true if, as proposed, future benefit increases are tied to the cost-of-living. The escalator, or tie-in, is an excellent proposal, especially if the starting base is adequate. Certainly at the minimum level it is not.

The last benefit improvement was effective February 1968, when the Consumer Price Index stood at 119.0. By September 1969, the C.P.I. had risen to 129.3 or up 8.7%.

It is proposed that the H.R. 14080 increases go into effect in March 1970, benefits payable thereafter. By then the increase in the cost-of-living, since the last increase, could well exceed 10%. Thus no real increase would be provided. We submit, therefore, that there should be at least a 15% overall rate of increase effective as soon as possible.

We think it is noteworthy that H.R. 14430, pending before this Committee would provide a 50% increase in total benefits over the next two years. For this reason, and its other provisions, H.R. 14430 deserves careful consideration.

With reference again to H.R. 14080, it is desirable to relate increases, in future to increases in the C.P.I. if: a) the starting point is adequate and; b) the public policy is established that beneficiaries will share in the economy's real growth. Otherwise, many of them are condemned to a substandard existence.

The 1938 earning base of \$3,000 covered all of the earnings of some 97 percent of the covered workers. The tax base has not kept pace since. The present base of \$7,800 covers all of the earnings of 79.7 percent of covered workers. As a result the tax rates have had to go up and workers' earned benefits are now based on a smaller portion of their earnings.

The Administration's proposal provides an escalator on the earnings' base after 1972, and we endorse this.

We endorse the proposed increased widows' benefits, the computation of average wage ending at age 62, for men, and the liberalized retirement test raising the earnings exempted from \$1,680 to \$1,800. Also of value is the proposal to continue childhood disability benefits to age 22, as against 18 as at present.

A further purpose of our testimony today is to offer support to the fine work of this Committee and the Congress in developing a program of health care for elderly citizens which has brought to millions of these people a security and dignity most appropriate to their state of life and lowered earning power. It is our belief that to face the risk of economically catastrophic illness significantly increases the burdens of old age and that the Medicare program has made enormous progress toward alleviating this cause of grave concern to the elderly. The program should be continued and improved, so that the needed care can continue to be provided through the cooperation of the government and the thousands of privately sponsored institutions, and services, including those under Catholic auspices.

We are concerned, however, that the rapidly rising costs of health be controlled so that those not covered by some form of health insurance will be able to afford needed care in the years to come. Another concern is the critical shortage of

health manpower, which puts tremendous pressure on existing manpower resources and can prevent the adoption of more efficient and effective methods of care. A large proportion of hospital and other health care expenses are for personnel. In large measure the rise in costs has been due simply to an overdue adjustment in the wages paid hospital employees. However, certain of the increases in costs appear to be due to a shortage of adequately trained individuals and the resultant competition for their services. We would hope that health care personnel will continue to make progress toward full earnings equality with other workers in those areas where they have not already achieved it. We urge this Committee to do everything in its power to assist in the training of additional personnel to serve in the health field, and believe that unless this problem is attended to with considerable effort, the future of our whole health care system may be in jeopardy.

We are confident that this Committee realizes that health care costs which have increased—as a major factor—due to higher wages can be reduced by more efficient means of utilizing existing resources, particularly by adopting methods which prevent the need for intensive and acute care. We are further confident that attempts to deal with rising costs will not have the effect of disabling health care facilities from continuing to provide high quality services in a developing system. The Medicare program should not operate to deprive those persons not covered by the program of the services they rightfully deserve, and should not fulfill the health care expectations of the elderly at the expense of future generations. As health care costs have risen, so has the interest and ability of those serving in hospitals and other institutions to deal realistically and honestly with the problem. We offer our support to all efforts which will deal effectively with the costs of health care while preserving the quality and progress inherent in our system, and insure a fair system of cost allocation between Medicare patients and others served. We particularly support the "Statement on the Financial Requirements of Health Care Institutions and Services" of the American Hospital Association as a very practical mechanism to achieve this goal.

Health care institutions have recognized their special obligation to the community served, and are now reshaping the manner in which they identify this responsibility. We see the vehicle of community-wide planning as an appropriate component in overall process. Planning in the context of a competent, impartial community-supported agency which is apart from the hospitals and other health care institutions it reviews, has become a source of major assistance to the community and particularly to the institutions themselves. Where planning is functioning well, the benefit of seeing one's self through the eyes of the entire community has been proven, and institutions have responded enthusiastically to this significant source of support and direction for their future service role. By helping to restructure the health care system into a more coordinated, cooperative one, the benefits of planning in terms of increased efficiency and a higher degree of planning accuracy are apparent to all who have seen it work well even on a short term basis. We recognize that only through full participation and support of proper planning mechanisms can health care institutions continue to call for the financial support of government and private payors, and support this Committee's efforts to insure that health care planning will serve its announced goals.

We fully support the pleas of the American Hospital Association to include all those over 65 under Medicare, for the reasons stated in its testimony.

We believe that this Committee should make every effort to include payment for the drugs and other medication frequently required by older people on a life-sustaining basis at the earliest possible date. We recognize the difficulties of estimating the costs of such coverage at the present time, but fear that the cost of hospitalization caused by a failure to use unaffordable drugs could be even greater. We would support payment for such drugs, if properly determined to be necessary, at an increasing rate after, for example, the first hundred dollars had been paid by the beneficiary. It might be appropriate in such a program to require the supervision of the patient's physician and the outpatient department of a general hospital, incorporating the protection of utilization review.

Fiscal and supervisory problems should not pose such insurmountable obstacles that the Federal government in practical effect creates financial incentives to hospitalization by failing to reimburse for preventive care and sustaining medication. We further encourage this Committee to direct its attention to ways of providing all forms of preventive health care service to Medicare beneficiaries and to ways of stimulating this coverage under other insurance programs, both public and private. We believe that there is now ample evidence that

preventive care is less expensive in the long run and is productive of a far higher standard of health than reimbursement programs which confer benefits for illness only.

Encouragement and assistance should be given to those prudent enough to desire a regular medical examination and the Federal government should likewise welcome this opportunity to pay for early diagnosis and treatment of illness at doctor's office and hospital outpatient rates. In elderly citizens particularly, the efforts to cut medical costs can fruitfully begin with efforts to avoid illness rather than only look for more efficient ways of providing intensive care once it has become necessary. It is our belief that only by encouraging preventive care any system of health insurance realistically hope to change some of the unfortunate and very expensive patterns of health care delivery in this country, and we believe that in the long run the patient and the taxpayer will be better served with this shift of focus.

We look forward to the time when all Americans can feel the security and enjoy the health benefits of adequate and affordable health care, and commend the efforts of this Committee for helping make that goal a reality.

Mr. BURKE. Thank you, Mr. Cosgrove.

I neglected, when you approached the podium here, to mention that Monsignor Murray was an original member of the advisory group on the medicare program and he is recognized as an authority and has expertise on these matters.

I would like to ask you a question in connection with this work-training program and I am particularly concerned about how it would affect mothers of youngsters over 6 years of age on compelling them to take training and employment. Do you believe this is a good policy in raising a family and if the mother believes that she should be at home don't you believe that she should have the right to decide whether or not she should accept this training program and work program?

Mr. COSGROVE. Yes, sir, we do. We are in the anomalous position in this bill as it now stands that the wife in a family receiving benefits, the wife of a husband who could work or could register, would not have to apply but the lady more unfortunately widowed, for example, who is therefore head of the family would as a precondition to benefits for herself as head of the family under the proposal have to register for the service training or work referral. The suggestion we would make would be that it could be very important that the maternal influence exist in the home, continue in the home, even if the smallest child, the youngest child, is over 6 and it is improper, we would suggest, and inappropriate, to, in effect, require as a condition of benefits that this lady enter the training program or this employment. Many people will choose to do this. Many people will choose to. We certainly wouldn't oppose their doing this, but the option, we think, should be theirs that they in all the circumstances could make the judgment as to whether they should proceed or not. I think the key point here is, sir, the value of the mother continually in the home, her guidance, her influence, for the stability of the family and the children.

Mr. BURKE. As far as day care centers are concerned, I believe testimony was given here by Governor Rockefeller and many other persons who indicated there is a tremendous shortage of day care centers throughout the entire Nation. This being so, where do you think they could put these children if we don't have day care centers for them?

Mr. COSGROVE. Mr. Chairman, that is right, they meet the question not only of are the facilities available but whether this is as desirable an arrangement as the child to be in the home. This is not to say that

day care centers do not perform a useful function and are not good, but it is to say that, given the option, we would opt if this was the mother's choice, for her capacity, her capability of staying in the home with the child because we would think at best the day-care service is a second-best choice.

Mr. BURKE. Are there any questions?

Mr. CONABLE. Yes.

Mr. BURKE. Mr. Conable.

Mr. CONABLE. Thank you.

We would seem to be putting increasing emphasis on comprehensive health planning, including the planning of hospitals. Is the Catholic Church running into any serious problems with this? I know that in some communities there has been the attitude taken that more important than simply the availability of beds in areas where there are very substantial Catholic populations is that the church should not be subject to restriction, for instance, the building of a Catholic hospital if a substantial part of the population wanted to be able to provide medical service through a Catholic institution. Has there been any great problem, for instance, of a religious nature growing out of the comprehensive health plan which is now becoming quite rigid as a matter of law in States like New York, or have these problems been worked out pretty well in practice through the understanding of the planning bodies involved?

Mr. COSGROVE. Mr. Conable, I will ask Monsignor Murray to reply to that.

Monsignor MURRAY. Thank you, Mr. Cosgrove.

On comprehensive health planning, we have taken the position we are firmly in favor of this and we must cooperate with all the area and statewide planning groups. There has not come to our attention any religious problem in connection with these areawide planning groups. There is a problem in some areas where there is a political difficulty.

Mr. CONABLE. What do you mean by a political difficulty?

Monsignor MURRAY. You have to be in with the in group. This is perhaps our fault in some areas that we have not participated in community activity as we should have, so that we are on the fringe, but now with the turning out of our own institutions of our sisters getting out of the engineroom and going up on the bridge, we are able to see where we fit better into community activity so that we are more community oriented now than we were 20 years ago.

Mr. CONABLE. The trend toward increasing institutional planning then in the health field has not created any serious problems for you as far as you know in any part of the Nation?

Monsignor MURRAY. No, not as far as our church-oriented hospitals or as far as our other church denominations. We have a third of our facilities, 285 hospitals in this country, where there is no other health care facility within reasonable traveling distance. Less than 2 percent of the population we serve is Catholic. So we are rendering a community service.

Mr. CONABLE. Oh, I don't think there is any doubt of that, sir.

Monsignor MURRAY. In fact, our non-Catholic patients are more than Catholics—52 percent.

Mr. CONABLE. I recall that at the outset of the New York State's comprehensive health planning law there was some concern expressed

about this very problem and about whether the planning bodies would understand the desires of the Catholic community in relation to the generation of hospital beds. There was some reluctance initially at getting this particular part of hospital planning made too rigid in the law. Apparently that has not become a serious problem, and I am very glad to hear it.

Monsignor MURRAY. No. It would be a problem, as I say, in one or two areas, but most of it is a problem because of ignorance, not how we would plug in, so to speak, to the entire system.

Mr. CONABLE. Thank you very much, sir.

That is all, Mr. Chairman.

Mr. BURKE. Thank you. We thank you. Mr. Cosgrove, and Monsignor Murray and Father Burns, for your appearance here today and I can assure you the staff will study the entire statement very, very thoroughly and give it careful consideration.

Mr. COSGROVE. Thank you, Mr. Chairman.

Mr. BURKE. The committee is in recess now until 2 p.m., and our leadoff witnesses at that time will be Paul Hill and Robert Finnegan.

The committee stands in recess until 2 p.m.

(Whereupon, at 12:28 p.m., the committee recessed, to reconvene at 2 p.m., the same day.)

AFTERNOON SESSION

Mr. ULLMAN (presiding). The committee will be in order.

Our next witness is Mr. Hill.

We are glad to welcome you before the committee, Mr. Hill. If you will tell us for whom you are testifying, and also identify your colleague, I would appreciate it, and then you may proceed as you see fit.

STATEMENT OF PAUL D. HILL, PRESIDENT-ELECT, INTERNATIONAL ASSOCIATION OF HEALTH UNDERWRITERS; ACCOMPANIED BY ROBERT J. FINNEGAN, EXECUTIVE VICE PRESIDENT

Mr. HILL. Thank you, Mr. Chairman.

My name is Paul D. Hill. I am from Indianapolis, Ind. I am president-elect and legislative chairman of the International Association of Health Underwriters.

Accompanying me is Robert J. Finnegan, executive vice president of the association, from Hartland, Wis., where the national headquarters and executive offices of our organization are located.

Our organization is made up of some 5,000 members in nearly 100 State and local associations all over the country. It is our members, along with members of the National Association of Life Underwriters and the property-casualty insurance agents, who sell and service health insurance—who daily talk to people about their health insurance needs.

This is the fifth time that our organization has had the privilege of sharing our thinking with a congressional committee in a little over a decade, and once again we thank you for the privilege of appearing.

There have been literally dozens of social security bills that have been introduced at this session of Congress, so that rather than address ourselves to any particular bill, we would like the privilege of mentioning five or six different points that we think are extremely important in regard to all of them.

First of all, the administration has proposed a 10-percent increase in cash benefits. This we favor, with the stipulation that the increase be limited to 10 percent.

During the period since social security benefits were last increased, the cost of living has gone up markedly, there is no question about that, and there is convincing evidence that an increase is in order.

We sincerely believe, however, that this law change should go still further, and should provide that any future increases beyond the one under discussion will be tied to the cost-of-living index.

This suggestion was included in our testimony before the Senate Finance Committee in September of 1967, and nothing has happened in the interim to make us believe that this is a bad idea. As a matter of fact, I think we are probably stronger in our belief that this is the case now than we were even then, if this is possible.

In this connection, we would like to point out one pertinent fact, which unfortunately seems to be overlooked almost continuously by a few segments of our society. This is that social security was designed as a foundation, a floor of benefit, and when social security was put into effect in January, 1937, that social security was put into effect to provide originally supplementary benefits, and that people were encouraged to own homes, own bonds, anything that was available in the way of property.

We would like to reaffirm our faith in these things, and to further say that we believe social security should be maintained as a basic floor of benefits, and that the individual should be encouraged to continue to build upon them, and to use social security benefits as a base.

For that same reason, and in that same connection, we believe that the death benefit under social security should not be increased, but should be kept at the present level.

We would like to address ourselves, if we may, to one thing that seems to be coming up more and more, and that we think is vitally important, and that is the temptation to expand medicare benefits and to increase the requirements upon the States under medicaid.

Gentlemen, I would like to read this in the record, and say personally to you gentlemen that are here that I think the reason that this should not be expanded is this, and our association believes this very strongly: That it is simply a matter of economics. We don't think that we can afford any more Government intervention in the medical field. Very frankly, it is just too expensive.

While all costs have gone up in the last few years, none has gone up as fast as the cost of medical care. This is due to a lot of things, of course. It is due to inflation, due to the affluence of our society, due to improved medical care that has been brought about by scientific advances.

However, if we can believe the record, we don't think that any other factor is tied so closely to the increase of medical costs as the intervention of the Federal Government.

Attached to our testimony, which I hope you will take a look at, are charts showing the increase in medical care. These charts were provided by Indiana Blue Cross-Blue Shield, which is by far the largest purveyor of hospital benefits in Indiana, and this is true almost universally across the Nation, that some section of Blue Cross-Blue Shield handles more health care benefits than any other organization.

In those charts, we refer to the participating and cooperating hospitals. Those constitute practically every hospital in the State of Indiana, also the hospitals that are in cities neighboring Indiana very closely, in southern Michigan, in eastern Illinois, in northern Kentucky, and in western Ohio.

I would like to call your attention to the fact that the charts show that from 1960 to 1963 the average cost of hospitalization on a case basis increased \$2.82 per quarter, or \$11.28 per year. During 1964 to 1966, the increase was \$3.61 per quarter, or \$14.44 per year. Then the impact of medicare was fully felt, and the increase skyrocketed to \$12.68 per quarter, or \$50.72 per year.

To put it even more simply, and more bluntly, hospital costs increased four times as fast after the advent of medicare as they did before medicare.

I think that does not tell all the picture. I have a quotation from Harry Hineman, vice president and actuary of Indiana Blue Cross and Blue Shield, which company administers medicare in Indiana:

When medicare was implemented a cost reimbursement formula was adopted paying "cost" plus two percent. Cost data developed by hospitals in my own state indicate that our hospitals require approximately "cost" plus six percent or seven percent if we are to have the same continuing improvement and advances in the next 10 years that we have experienced over the past 10 years. In other words, if every patient was on the "cost" plus two percent formula for payment to the hospital, our advance in medicine and institutional care would come to a fast halt and subsequent deterioration would begin.

Hospitals have contributed to improve, scientific advances have been developed, and someone other than medicare has been footing the bill. As a matter of fact, medicare patients receive the benefits thus developed without sharing in the costs. To further compound the problem, the two percent factor has now been eliminated. Since one patient in three is a medicare patient, the elimination of the two percent will cost all the rest of us one percent more on our hospital bill.

There is no reason to think that Indiana is out of the ordinary in this regard, that costs have increased in Indiana more rapidly than they have elsewhere. As a matter of fact, daily newspaper stories as well as testimony already delivered before this committee both indicate that in some sections of the country hospital costs have gone up even more rapidly than the examples given here.

As a matter of fact, we have a lot of evidence to the fact that it is not. You have heard various people testify during the hearings. They have pointed out that hospital costs around the country in a great many instances have gone up even more rapidly than they have gone up in the State of Indiana.

Unfortunately, the end is not in sight. Current responsible predictions indicate that next year hospital costs will go up more than 16 percent, in 1970 alone, with the increases in 1971 to be that much or even more.

And this is, of course, a compounding figure, as you all realize. Each year the increase is predicated on a larger base. And beyond 3 or 4 years into the future, few responsible individuals are even willing to predict.

Gentlemen, we believe that should medicare be expanded, that would mean a still smaller segment of our people paying a larger portion of hospital costs, as mentioned above, since medicare is subsidized by those not under its provisions.

In this connection, I would like to add a couple of points to our printed testimony, if I may.

Mr. Walter Reuther this morning when he was testifying made the statement that insurance companies have failed to hold medical costs down.

Gentlemen, I would like to say to you that I think this is like saying that the UAW-CIO failed to keep Studebaker and Packard in business. The statements have the same relevancy to each other.

Insurance companies do not determine hospital costs. As you know, they pay them on an insurance basis.

One other thing in this connection is that the day before yesterday a young man came into my office whom I became acquainted with about 3 years ago, who is graduating from college in January. He was planning when he got out of college in January to go on to medical school.

He sat down and we were visiting, and he said, "I have decided not to be a doctor. I am going to be a veterinarian."

This surprised me a little bit. I said, "Why in the world do you want to be a veterinarian?"

He said, "I have decided that the Federal Government will stay out of that area longer than they are going to stay out of personal medicine."

And, gentlemen, I think that this feeling is prevalent among a great many young men around the country. I think there are fewer and fewer people all the time attracted to the medical field, because of the controls that are slowly but surely being put on it.

In summary, we believe, the Internal Association of Health Underwriters believe:

1. That retirement, survivor, and disability benefits should be increased a maximum of 10 percent.
2. That any increases in future years should be tied to the cost of living.
3. That death benefits under social security should be maintained at their present level.
4. That medicare should not be expanded to cover a greater segment of our population.

In this connection, we do support House bill 9835, which Representative Richard Fulton of Tennessee authored. We support probably all of that bill, with one exception. There is one thing that we are very concerned about, and that is this: We have a reservation about the fact that the bill requires that preexisting conditions be covered.

We are not exactly certain whether or not this is possible, and at what cost it would be possible, if it is.

Gentlemen, this ends our formal testimony. We thank you for the privilege of appearing.

Mr. CORMAN (presiding). Thank you very much, Mr. Hill.

Does Mr. Finnegan have a statement?

Mr. HILL. No, sir.

Mr. CORMAN. Without objection, we will at this point in the record insert your full statement, with the addendum.

Mr. HILL. Thank you.

(The prepared statement follows:)

STATEMENT OF PAUL D. HILL, INTERNATIONAL ASSOCIATION OF HEALTH
UNDERWRITERS

Mr. Chairman and members of the committee, my name is Paul D. Hill, from Indianapolis, Indiana. I am president-elect and legislative chairman of the International Association of Health Underwriters. Accompanying me is Robert J. Finnegan, executive vice president of the association, from Hartland, Wisconsin, where the national headquarters and executive offices of our organization are located.

Our organization is made up of some 5,000 members in nearly 100 state and local associations all over the country. It is our members, along with members of the National Association of Life Underwriters and the property-casualty insurance agents, who sell and service health insurance—who daily contact people about their health insurance needs.

This is the fifth time that our organization has had the privilege of sharing our thinking with a Congressional Committee in a little over a decade, and once again we thank you for the privilege of appearing. Since the subject before this Committee is one that affects practically every living American, you are to be congratulated for doing as you are doing, gathering testimony from practically every segment of our society.

Dozens of bills to alter and amend Social Security have been introduced at this session of Congress, and since this is true, the bill that is finally enacted into law will probably be not any one bill but a compromise involving several. For that reason, we will comment on the various facets of the law in general, rather than upon any one bill in particular.

The administration has proposed a 10% increase in cash benefits. This we favor, with the stipulation that the increase be limited to 10%. During the period since Social Security benefits were last increased, the cost of living has gone up markedly, and there is convincing evidence that an increase is in order. We sincerely believe, however, that this law change should go still further, and should provide that any future increases beyond the one under discussion will be tied to the cost of living index. This suggestion was included in our testimony before the Senate Finance Committee in September of 1967, and nothing has happened in the interim to make us believe that this is a bad idea. Intervening events have rather tended to confirm our thinking. If Social Security is to be respected by the responsible elements of our society, it must not continue to be at the beck and call of every politician who is attempting to gain votes by increasing benefits.

In this connection, we would like to point out one pertinent fact, which unfortunately seems to be overlooked almost continuously by a few segments of our society. This is that Social Security was designed as a foundation, a floor of benefits. This concept was included in the recommendations made by the original presidential commission in 1935, whose activities resulted in the Social Security law, and has been reaffirmed since, a great many times. Yet, there still seems to be a tendency on the part of some people and some groups to think that Social Security should provide adequate retirement income without supplementation, and that benefits in the survivor and disability areas should be equally large. This feeling should be strenuously resisted by those charged with the public trust of making our laws. This country reached the greatness it has attained by encouraging private thrift, not by advocating public largess. The ownership by every individual of life insurance, health insurance, stocks, bonds, mutual funds, real estate and other kinds of property should be encouraged not only by commentary, but also by the laws we put forward to govern our people.

For this same reason, the cash death benefit under Social Security should not be increased, but kept at the present level.

The temptation to expand medicare benefits or to increase the requirements upon the states under medicaid benefits should be strenuously resisted. The reason is simply one of economics. We can't afford more government intervention in the medical field. It is too expensive. While all costs have gone up in the last few years, none has gone up nearly so fast as the cost of medical care. This is due, of course, to inflation, to the affluence of our society, to improved medical care brought about by scientific advances. However, if we can believe the record, and it is there for all of us to see, no other factor has had so great an impact on the cost of medical care during the last few years as has the intervention of government.

The attached charts were compiled by Blue Cross-Blue Shield, which is by far the largest purveyor of hospital benefits in the state of Indiana, as it is in practically every other area of the nation. The "participating and cooperating" hos-

pitals referred to include practically every public hospital in Indiana, as well as several in cities adjacent to Indiana located in other states. The charts show that in 1960-1963, the average cost of hospitalization on a case basis increased \$2.82 per quarter, or \$11.28 per year. During 1964-1966, the increase was \$3.61 per quarter, or \$14.44 per year. Then the impact of medicare was fully felt, and the increase skyrocketed to \$12.68 per quarter, or \$50.72 per year. To put it even more simply, hospital costs increased four times as fast after the advent of medicare as they did before medicare!

But that isn't all. Let me quote a few words from Harry Hineman, Vice President and actuary of Indiana Blue Cross and Blue Shield, which company administers medicare in Indiana. "When medicare was implemented a cost reimbursement formula was adopted paying 'cost' plus 2%. Cost data developed by hospitals in my own state indicate that our hospitals require approximately 'cost' plus 6% or 7% if we are to have the same continuing improvement and advances in the next 10 years that we have experienced over the past 10 years. In other words, if every patient was on the 'cost' plus 2% formula for payment to the hospital, our advance in medicine and institutional care would come to a fast halt and subsequent deterioration would begin. Hospitals have continued to improve, scientific advances have been developed, and someone other than medicare has been footing the bill. As a matter of fact, medicare patients receive the benefits thus developed without sharing in the costs. To further compound the problem, the 2% factor has now been eliminated. Since one patient in three is a medicare patient, the elimination of the 2% will cost all the rest of us 1% more on our hospital bill."

There is no reason to think that Indiana is out of the ordinary in this regard, that costs have increased in Indiana more rapidly than they have elsewhere. As a matter of fact, daily newspaper stories as well as testimony already delivered before this committee both indicate that in some sections of the country hospital costs have gone up even more rapidly than the examples given here.

And the end is not in sight. Current responsible predictions indicate that hospital costs will go up more than 16% in 1970 alone, with the increases in 1971 to be that much or even more. And this is of course a compounding figure, as you all realize. Each year the increase is predicated on a larger base. And beyond three or four years into the future few responsible individuals are even willing to predict.

Should medicare be expanded, that would mean a still smaller segment of our people paying a larger portion of hospital costs, as mentioned above, since medicare is subsidized by those not under its provisions.

In summary, we, the members of the International Association of Health Underwriters recommend the following:

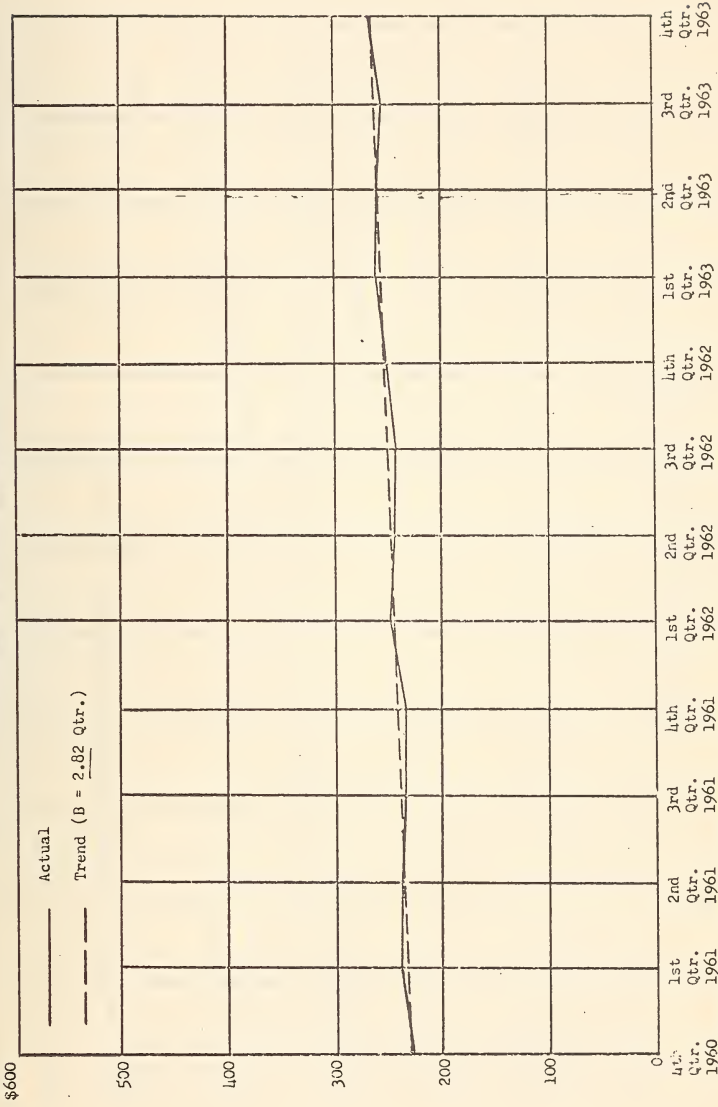
1. That retirement, survivor and disability benefits be increased a maximum of 10%.
2. That any increases in future years be tied to the cost of living, and that current amendments to the law stipulate that method for such increases. This would help take the Social Security law out of politics, a definite improvement.
3. That death benefits under Social Security be maintained at their present level.
4. That medicare not be expanded to cover a greater segment of our population.

Mr. Chairman, members of the committee—thank you for the opportunity to present this thinking of our members.

Cost per Case

Full Service

Participating and Cooperating Hospitals

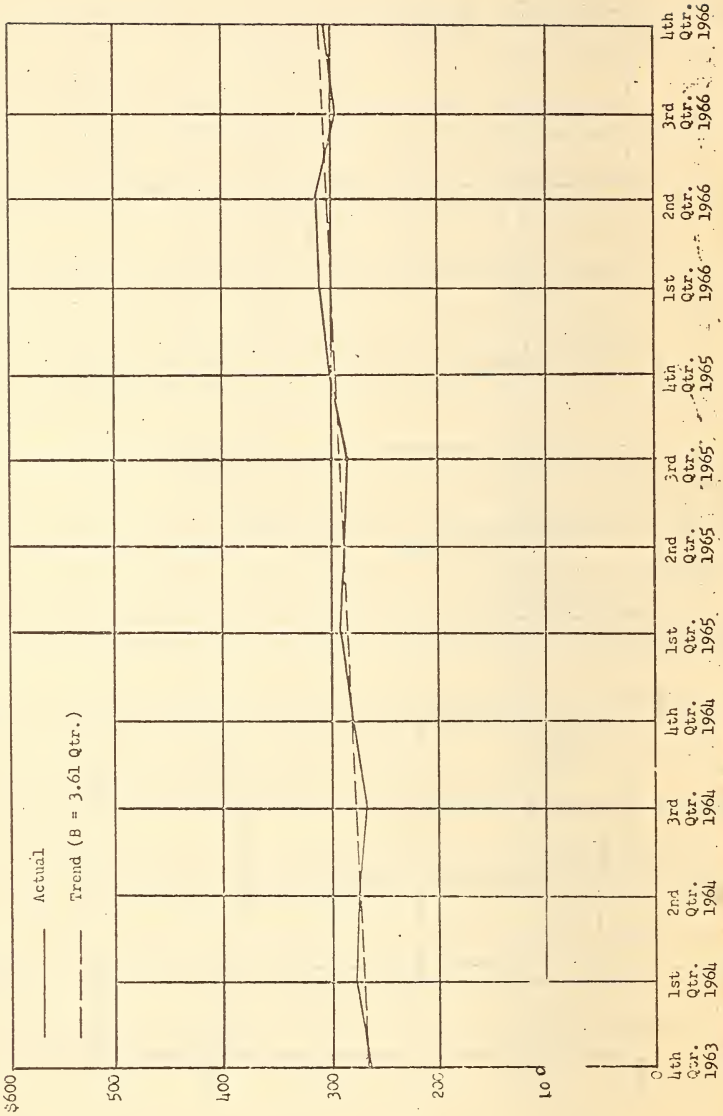


SOURCE: Blue Cross-Blue Shield-State of Indiana

Cost per Case

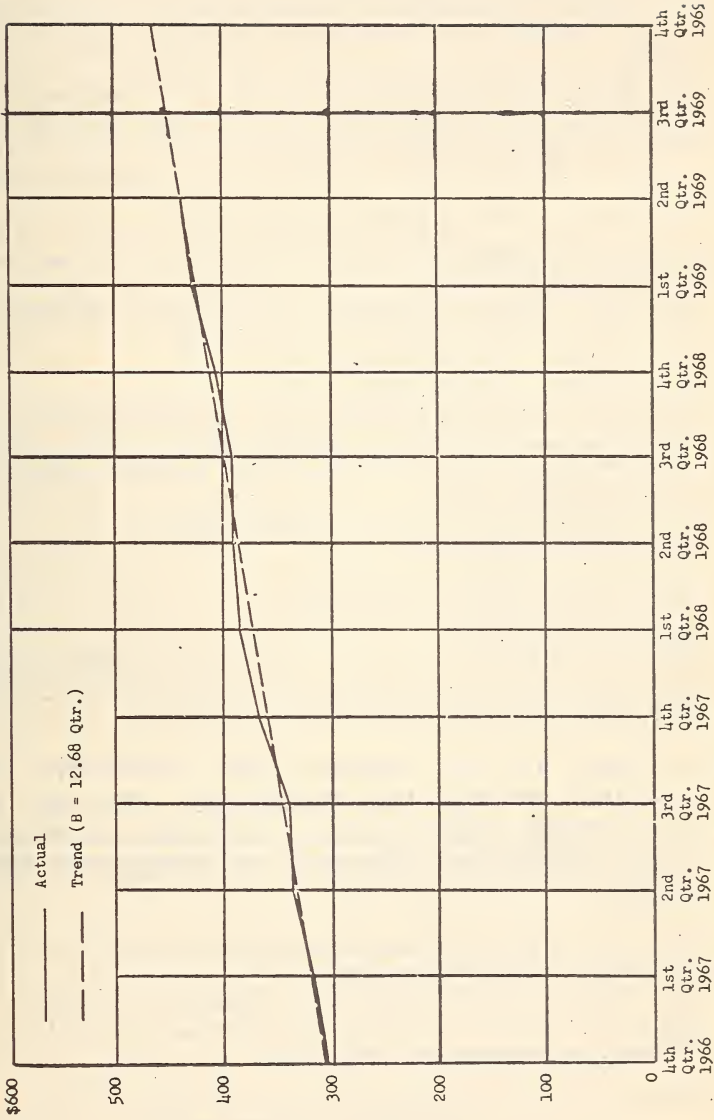
Full Service

Participating and Cooperating Hospitals



SOURCE: Blue Cross-Blue Shield-State of Indiana

Cost per Case
Full Service
Participating and Cooperating Hospitals



SOURCE: Blue Cross-Blue Shield-State of Indiana

Mr. CORMAN. Are there questions?

I want to ask a couple of questions.

Did the advent of private health insurance have any effect on hospital costs? As I remember it, the whole field of private health insurance is a relatively new development, expanding greatly after World War II.

Mr. HILL. I would say that it has had, yes. I would say that private health insurance has contributed to health care costs, but not as substantially as has the advent of medicare.

I have no statistics with me to back this up, but that would be my opinion.

Mr. CORMAN. Would that be because of the number of people involved, and because medicare has brought in a great many more people than private policies?

Mr. HILL. Yes, sir. It has been overutilization and failure of present facilities, I think, to keep up with the needs.

Mr. CORMAN. Would Federal programs such as the Hill-Burton Act increase the cost of medical care?

Mr. HILL. I would not say that that increases the cost of medical care. Of course, it increases taxation, and everything else, because in Hill-Burton, of course, the thing that has been primarily done is to build medical facilities.

Mr. CORMAN. Yes, sir. I have no other questions.

Do you have questions?

Mr. CONABLE. I have no questions.

Mr. CORMAN. Thank you very much.

Mr. HILL. Thank you.

Mr. CORMAN. Our next witness is Mrs. Roberta Hunt, executive director of the National Council for Homemaker Services, Inc.

Mrs. Hunt, do you have a prepared statement?

STATEMENT OF MRS. ROBERTA HUNT, EXECUTIVE DIRECTOR, NATIONAL COUNCIL FOR HOMEMAKER SERVICES; ACCOMPANIED BY MRS. ASHER YAGUDA, PRESIDENT, AND MRS. TINSLEY ADAMS, CHAIRMAN, COMMITTEE ON LEGISLATION AND SOCIAL POLICY

Mrs. HUNT. Yes, I do have a prepared statement, and I would like it to be made a part of the record.

Mr. CORMAN. Fine. We have it now. Thank you very much.

Without objection, we will include your full statement in the record. (The prepared statement follows:)

PREPARED STATEMENT OF ROBERTA HUNT, EXECUTIVE DIRECTOR, NATIONAL COUNCIL FOR HOMEMAKER SERVICES, INC.

My name is Roberta Hunt and I appear before you today in my capacity as Executive Director of the National Council for Homemaker Services, Inc., with offices at 1740 Broadway in New York City. I am accompanied by two members of our Board of Directors: Mrs. Asher Yaguda, President; and Mrs. Tinsley Adams, Chairman of the Committee on Legislation and Social Policy. This organization is voluntarily supported, but its membership is drawn from public as well as voluntary health and social welfare agencies in every part of the country. It also includes individual citizens, and industrial corporations interested in helping the Council to achieve its purposes.

PURPOSE OF THE COUNCIL

The National Council for Homemaker Services was incorporated in 1962 because most of the leading organizations dealing with welfare and health problems had become convinced that homemaker services are indispensable in an industrialized society and basic to the prevention and resolution of many of the Nation's social, economic and health problems. We seek to broaden understanding and recognition of these services to individuals and families and to promote their orderly development on a scale commensurate with the urgent need. It is a need which most people have encountered personally, or among their friends and relatives, and which, in far too many cases, is not being met, either because there are so few of these services in the country, or because those that do exist, cannot meet the demand.

WHY WE WISH TO BE HEARD

We are here because we recognize that much of the expansion and development of these services that has taken place in recent years has been assisted and encouraged by Congressional action. In large measure, the direction of their future growth and usefulness for all Americans can be determined by decisions made in these halls.

HOMEMAKER SERVICE—WHAT IT IS

What is homemaker service? It goes by a variety of names. For purposes of this testimony I will use the generic term, "homemaker service," but whether it is called "homemaker service," "home health aide service" or "homemaker, hyphen, home health aide service" it is describing an in-home-care program under auspices of a governmental or non-profit health or welfare agency. These include visiting nurse associations; local welfare departments; and family and child welfare service organizations under a variety of auspices. Some provide homemaker service as their only service, or for just one age group or problem group such as for the aged, children, or the sick. Some are agencies serving a wider range of clientele or problem categories. In any event, qualified persons, employed, trained, and supervised by these local agencies are sent into homes, as needed, to help the sick; the aged; the mentally ill; the retarded; the disabled; and families with children, to maintain themselves in their own homes and wherever possible to raise the quality and the level of their daily living. These "homemakers" work under the supervision of a nurse, a social worker or another member of the professional team responsible for helping to resolve the problem that made the service necessary in a particular home.

WHAT IT DOES

For families with children.—There are dozens of different kinds of circumstances in which families need homemaker service. For example, a father has been warned by his employer that he will lose his job if he continues to require time off because of problems at home. His wife has returned from a third hospitalization with a diagnosis of terminal cancer. She is beginning to experience severe pain and mental disturbance. The children are trying to be helpful but look depressed and neglected. The thirteen-year old daughter is beginning to truant from school and is very defiant toward all the adults with whom she is in contact.

The homemaker in this situation has many tasks, all related to keeping this family intact and stabilized, and to helping each of its members to be better able to cope with the impending death of a needed and loving mother. The homemaker sees to it that the children get off to school with clean clothes and with homework done. She markets, she does light cleaning. She helps care for and sustain the mother in accordance with the medical plan. She gets acquainted with the troubled adolescent and under guidance from the mother and father, as well as from the social worker, she helps her to face the sad situation in a more "grownup" way. She sees to it that a meal is ready when the father comes home tired from work. She comforts the younger children and gets them to playing happily again, as children must, no matter how sad or difficult the family circumstances.

Many other examples come to mind. For one, there is the young fatherless family which had waited a year to get out of a rat-infested tenement and now,

without help from a "teaching" homemaker, will not be able to "make it" in the new housing project because the immature and disorganized mother has never learned how to run a house and care properly for children. Certainly she will be unable to take full advantage of opportunities for training and later employment unless she has the help she needs now to become better organized and better able to manage her money and her family. As one mother expressed it, "lots of people have criticized the way I took care of my house and my family, but this is the first time anybody has really showed me how I could do better."

For older people.—The usefulness of these in-home-care services are not confined to the care and protection of children. On the contrary, they have been found to be equally essential for adults, and especially for our burgeoning aged population. With the help of a homemaker—sometimes for only a few hours each day—an aging couple who dread the thought of a nursing home or institution, are able to maintain themselves in their own home, thus not only living a more satisfying life, but also avoiding or postponing expensive institutional care, which, more often than not, is at public expense! In one instance, two hours of homemaker service, three times a week, enabled a 70-year old man with a heart condition to remain in his own home.

For the sick or disabled.—Homemaker service is also useful in problems of injury, illness, or disability, whether the person is old or young. Besides the usual tasks of food preparation and help with care of the home, extensive personal care may be necessary. Such homemakers have special skills or receive special training in care of sick people and work under nursing supervision. These homemakers, when they are dealing primarily with problems of illness, are often called "home health aides". Their services are invaluable in shortening or avoiding prolonged hospitalization or other expensive institutional care.

A BASIC SERVICE

In summary, homemaker services are a necessary component in any comprehensive approach to the problems of people. They are equally needed to deal with problems of child care; of aging; of illness; of disability; and handicap. Because of homemaker services, thousands of families have been kept together. Many children, and many old persons, have been spared from needless and costly care in institutions or foster homes. Because of dearth of homemaker services the reverse has happened to many more. It is a service that is frequently sought and needed by all Americans, poor and rich. And in 1969 America, it is a service that is in very short supply.

IDENTIFY HOMEMAKER SERVICE IN LAW

Because it is such a basic service in dealing with many problems of individual and family functioning, homemaker service should be specifically identified in pertinent titles of the Social Security Act, along with day care, full-time foster care, family planning and other essential services which *are* so identified. We would like to see your Committee give it emphasis as a first line of defense which in many instances can facilitate utilization of other services and opportunities.

Not to be overlooked by this Committee, is the added "plus" that if homemaker services were funded on the scale necessary to meet urgent need, useful job training opportunities could be opened up for thousands of women. A growing number of the homemakers working successfully in our local agencies were recruited from the ranks of welfare recipients.

IMPORTANCE OF CONGRESSIONAL ACTION

Through Child Welfare Services.—As has already been indicated, Congressional action has had much to do with making possible the development and extension of homemaker services. Various sections of the Social Security Act have made possible either the provision of homemaker service or the purchase of it from voluntary agencies. With the appropriations for Child Welfare Services under Title IV—Part B, for example, many states have been enabled to give leadership in developing these services. They have been able to demonstrate that it is often better, and also less costly, to provide needed help for children in their own homes during times of family crisis or breakdown, than to remove the children, hastily, and then have to maintain them for indefinite periods in institutions or other kinds of "temporary" out-of-home care arrangements. These Child Welfare Services' appropriations have been especially useful because they

have enabled provision of these services to children needing care and protection, whether or not their families were recipients of public assistance.

We would strongly urge that the appropriation for Child Welfare Services in 1970 be raised above the \$46 million dollar level of 1969, at least to the \$110 million dollar level authorized. This would make possible not only strengthened homemaker services but also many other important protective services for children.

Through the public assistance titles.—Many children in public assistance families have also benefited from the fact that homemaker service was one of the services for which it was possible to claim 75 percent reimbursement in amendments to Title IV, Part A of the Social Security Act. This made possible either provision of homemaker service or purchase of it from a voluntary agency. Similar provisions in the Act have made homemaker service possible for recipients of Aid to the Blind; Aid to the Permanently and Totally Disabled; and Old Age Assistance.

In the Medicare and Medicaid Programs.—The specific inclusion of "the services of a home health aide" in the provisions of both Title XVIII and Title XIX has stimulated a substantial increase in that one aspect of homemaker service concerned primarily with personal care of sick people as part of a medical plan.

Although the establishment of "home health aide services" as one of the reimbursable services under Health Insurance for the Aged has been an important step forward, serious operating problems are arising because of the comparatively narrow definition of services for which reimbursement is authorized in the Act, and the limited circumstances under which it is sanctioned.

Experience has indicated that in order to maintain seriously sick or disabled persons in their own homes and thereby to avoid costly care in medical institutions, it is necessary to have available a broad continuum of in-home-care and home maintenance services, some of which, though essential to the health and well being of sick people, are not usually thought of as "medical services". It is also essential that this range of services be continued beyond the acute stage of illness. The Federal regulations, however, that have resulted from the provisions of the law, limit reimbursement for service of a home health aide to an extremely narrow set of circumstances when the patient is acutely ill and concurrently receiving highly skilled nursing services.

Limiting coverage to the circumstances defined and restricted in Federal regulations results in strange contradictions such as permitting reimbursement for a patient to be bathed, but not the sheets to be laundered; food to be served, but not shopping for it or cooking it.

A recent¹ reinterpretation of the intent of the law by the Department of Health, Education, and Welfare has resulted in a requirement for even more restrictive practice than had previously been possible. A stroke victim, for example, whose condition has stabilized, but who continues, in the judgment of the nurse who is supervising the case, to need help from a home health aide in getting out of bed, getting meals, and carrying out other activities of daily living, is no longer eligible under Medicare for reimbursement to cover the home health aide's services.

In recent weeks, reports to the National Council for Homemakers Services indicate that, as a result of this even more restrictive interpretation, many agencies are being forced to notify Medicare patients currently receiving home health aide service that they are no longer eligible. For many there appears to be no other source for support of this service for which there is undisputed need and without which, much more costly nursing home or hospital care will be the inevitable and far more costly alternative.

Recommended Action.—We strongly urge that Congressional intent to avoid costly and prolonged hospitalization be reaffirmed through a broadened definition of eligibility for in-home-care service. This definition should make possible reimbursement for a broad range of homemaking, home maintenance, house-keeping and personal care services. These services should be available not only for the acutely ill but also for chronically ill and disabled patients. We believe these broadened definitions need to be incorporated into both Title XVIII and Title XIX. In this connection, we would like to call your attention to H.R. 13139, a bill introduced by Congressman Gilbert of New York, and others, which has been widely supported by many of our member agencies because in a small way it broadens the definition of reimbursable services and would therefore be one step toward resolving some of these problems.

¹ Bureau of Health Insurance Intermediary Letter No. 395, August 1969.

APPRECIATION

We appreciate this opportunity to appear before your Committee in behalf of Homemaker Service which we regard as basic and indispensable in our industrialized society. If further information in explanation of our position would be useful, we would be glad to provide it.

Mr. CORMAN. We are very pleased to have you with us. If you would like to identify your two associates for the record, that would be helpful.

Mrs. HUNT. Thank you.

I appear before you today in my capacity as executive director of the National Council for Homemaker Services, Inc., with offices at 1740 Broadway in New York City.

I am accompanied by two members of our board of directors: Mrs. Asher Yaguda, president; and Mrs. Tinsley Adams, chairman of the Committee on Legislation and Social Policy.

This organization is voluntarily supported, but its membership is drawn from public as well as voluntary health and social welfare agencies in every part of the country. It also includes individual citizens, and industrial corporations interested in helping the council to achieve its purposes.

PURPOSE OF THE COUNCIL

The National Council for Homemaker Services was incorporated in 1962 because most of the leading organizations dealing with welfare and health problems had become convinced that homemaker services are indispensable in an industrialized society and basic to the prevention and resolution of many of the Nation's social, economic, and health problems.

We seek to broaden understanding and recognition of these services to individuals and families, and to promote their orderly development on a scale commensurate with the urgent need.

It is a need which most people have encountered personally or among their friends and relatives, and which, in far too many cases, is not being met, either because there are so few of these services in the country, or because those that do exist cannot meet the demand.

WHY WE WISH TO BE HEARD

We are here because we recognize that much of the expansion and development of these services that has taken place in recent years has been assisted and encouraged by congressional action. In large measure, the direction of their future growth and usefulness for all Americans can be determined by decisions made in these halls.

HOMEMAKER SERVICE—WHAT IT IS

What is homemaker service? It goes by a variety of names. For purposes of this testimony I will use the generic term, "homemaker service," but whether it is called "homemaker service," "home health aide service," or "homemaker-home health aide service," it is describing an in-home-care program under auspices of a governmental or nonprofit health or welfare agency.

These include visiting nurse associations, local welfare departments, and family and child welfare service organizations under a variety of auspices.

Some provide homemaker service as their only service, or for just one age group or problem group, such as for the aged, children, or the sick. Some are agencies serving a wider range of clientele or problem categories.

In any event, qualified persons, employed, trained, and supervised by these local agencies are sent into homes, as needed, to help the sick, the aged, the mentally ill, the retarded, the disabled, and families with children, to maintain themselves in their own homes, and wherever possible, to raise the quality and the level of their daily living.

These "homemakers" work under the supervision of a nurse, a social worker, or another member of the professional team responsible for helping to resolve the problem that made the service necessary in a particular home.

WHAT IT DOES FOR FAMILIES WITH CHILDREN

There are dozens of different kinds of circumstances in which families need homemaker services.

For example a father has been warned by his employer that he will lose his job if he continues to require time off because of problems at home. His wife has returned from a third hospitalization with a diagnosis of terminal cancer. She is beginning to experience severe pain and mental disturbance. The children are trying to be helpful, but look depressed and neglected. The 13-year-old daughter is beginning to truant from school, and is very defiant toward all adults with whom she is in contact.

The homemaker in this situation has many tasks, all related to keeping this family intact and stabilized, and to helping each of its members to be better able to cope with the impending death of a needed and loving mother.

The homemaker sees to it that the children get off to school with clean clothes and with homework done. She markets, she does light cleaning. She helps care for and sustain the mother in accordance with the medical plan.

She gets acquainted with the troubled adolescent and under guidance from the mother and father, as well as from the social worker, she helps her face the sad situation in a more "grown-up" way.

She sees to it that a meal is ready when the father comes home tired from work. She comforts the younger children, and gets them to playing happily again, as children must, no matter how sad or difficult the family circumstances.

Many other examples come to mind. For one, there is the young fatherless family which had waited a year to get out of a rat-infested tenement and now, without help from a "teaching" homemaker, will not be able to "make it" in the new housing project because the immature and disorganized mother has never learned how to run a house and care properly for children.

Certainly she will be unable to take full advantage of opportunities for training and later employment unless she has the help she needs now to become better organized and better able to manage her money and her family.

As one mother expressed it, "Lots of people have criticized the way I took care of my house and my family, but this is the first time anybody has really showed me how I could do better."

FOR OLDER PEOPLE

The usefulness of these in-home-care services are not confined to the care and protection of children. On the contrary, they have been found to be equally essential for adults, and especially for our burgeoning aged population.

With the help of a homemaker—sometimes for only a few hours each day, or a few hours each week—an aging couple who dread the thought of a nursing home or institution are able to maintain themselves in their own home, thus not only living a more satisfying life, but also avoiding or postponing expensive institutional care, which, more often than not, is at public expense.

In one instance, 2 hours of homemaker services, three times a week, enabled a 70-year-old man with a heart condition to remain in his own home.

FOR THE SICK OR DISABLED

Homemaker service is also useful in problems of injury, illness, or disability, whether the person is old or young. Besides the usual tasks of food preparation and help with care of the home, extensive personal care may be necessary. Such homemakers have special skills or receive special training in care of sick people and work under nursing supervision.

These homemakers, when they are dealing primarily with problems of illness, are often called home health aides. Their services are invaluable in shortening or avoiding prolonged hospitalization or other expensive institutional care.

A BASIC SERVICE

In summary, homemaker services are a necessary component in any comprehensive approach to the problems of people. They are equally needed to deal with problems of child care, of aging, of illness, of disability, and handicap.

Because of homemaker services, thousands of families have been kept together. Many children, and many old persons, have been spared from needless and costly care in institutions or foster homes.

Because of dearth of homemaker services, the reverse has happened to many more. It is a service that is frequently sought and needed by all Americans, poor and rich. And in 1969 America, it is a service that is in very short supply.

IDENTIFY HOMEMAKER SERVICE IN LAW

Because it is such a basic service in dealing with many problems of individual and family functioning, homemaker service should be specifically identified in pertinent titles of the Social Security Act, along with day care, full-time foster care, family planning, and other essential services which are so identified.

We would like to see your committee give it emphasis as a first line of defense which in many instances can facilitate utilization of other services and opportunities.

Not to be overlooked by this committee is the added "plus" that if homemaker services were funded on the scale necessary to meet urgent

need, useful job training opportunities could be opened up for thousands of women.

A growing number of the homemakers working successfully in our local agencies were recruited from the ranks of welfare recipients.

IMPORTANCE OF CONGRESSIONAL ACTION THROUGH CHILD WELFARE SERVICES

As has already been indicated, congressional action has had much to do with making possible the development and extension of homemaker services. Various sections of the Social Security Act have made possible either the provision of homemaker service, or the purchase of it from voluntary agencies.

With the appropriations for child welfare services, under title IV, part B, for example, many States have been enabled to give leadership in developing these services. They have been able to demonstrate that it is often better, and also less costly, to provide needed help for children in their own homes during times of family crisis or breakdown, than to remove the children hastily, and then have to maintain them for indefinite periods in institutions or other kinds of temporary out-of-home care arrangements.

These child welfare services appropriations have been especially useful because they have enabled provision of these services to children needing care and protection, whether or not their families were recipients of public assistance.

We would strongly urge that the appropriation for child welfare services in 1970 be raised above the \$46 million level of 1969, at least to the \$110 million level authorized. This would make possible not only strengthened homemaker services, but also many other important protective services for children.

THROUGH THE PUBLIC ASSISTANCE TITLES

Many children in public assistance families have also benefited from the fact that homemaker service was one of the services for which it was possible to claim 75-percent reimbursement in amendments to title IV, part A, of the Social Security Act.

This made possible either provision of homemaker service or purchase of it from a voluntary agency. Similar provisions in the act have made homemaker service possible for recipients of aid to the blind, aid to the permanently and totally disabled, and old-age assistance.

IN THE MEDICARE AND MEDICAID PROGRAMS

The specific inclusion of the services of a home health aide in the provisions of both title XVIII and title XIX has stimulated a substantial increase in that one aspect of homemaker service concerned primarily with personal care of sick people as part of a medical plan.

Although the establishment of home health aide services as one of the reimbursable services under health insurance for the aged has been an important step forward, serious operating problems are arising because of the comparatively narrow definition of services for which reimbursement is authorized in the act, and the limited circumstances under which it is sanctioned.

Experience has indicated that in order to maintain seriously sick or disabled persons in their own homes, and thereby to avoid costly care in medical institutions, it is necessary to have available a broad continuum of in-home-care and home-maintenance services, some of which, though essential to the health and well being of sick people, are not usually thought of as "medical services."

It is also essential that this range of services be continued beyond the acute stage of illness.

The Federal regulations, however, that have resulted from the provisions of the law, limit reimbursement for service of a home-health aide to an extremely narrow set of circumstances, when the patient is acutely ill and concurrently receiving highly skilled nursing services.

Limiting coverage to the circumstances defined and restricted in Federal regulations results in strange contradictions, such as permitting reimbursement for a patient to be bathed, but not the sheets to be laundered; food to be served, but not shopping for it or cooking it.

A recent reinterpretation of the intent of the law by the Department of Health, Education, and Welfare—Bureau of Health Insurance Intermediary Letter No. 395, August, 1969—has resulted in a requirement for even more restrictive practice than had previously been possible.

A stroke victim, for example, whose condition has stabilized, but who continues, in the judgment of the nurse who is supervising the case, to need help from a home-health aide in getting out of bed, getting meals, and carrying out other activities of daily living, is no longer eligible under medicare for reimbursement to cover the home-health aide's services.

In recent weeks, reports to the National Council for Homemaker Services indicate that, as a result of this even more restrictive interpretation, many agencies are being forced to notify medicare patients currently receiving home-health aide service that they are no longer eligible.

For many there appears to be no other source for support of this service, for which there is undisputed need, and without which much more costly nursing home or hospital care will be the inevitable and far more costly alternative.

RECOMMENDED ACTION

We strongly urge that congressional intent to avoid costly and prolonged hospitalization be reaffirmed through a broadened definition of eligibility for in-home-care service.

This definition should make possible reimbursement for a broad range of homemaking, home maintenance, housekeeping, and personal care services. These services should be available not only for the acutely ill, but also for chronically ill and disabled patients.

We believe these broadened definitions need to be incorporated into both title XVIII and title XIX.

In this connection, we would like to call your attention to H.R. 13139, a bill introduced by Congressman Gilbert of New York, and others, which has been widely supported by many of our member agencies because in a small way it broadens the definition of reimbursable services and would therefore be one step toward resolving some of these problems.

APPRECIATION

We appreciate this opportunity to appear before your committee in behalf of homemaker service, which we regard as basic and indispensable in our industrialized society.

If further information in explanation of our position would be useful, we would be glad to provide it for the committee.

Mr. CORMAN. Thank you very much, Mrs. Hunt.

Mr. Conable.

Mr. CONABLE. Thank you, Mr. Chairman.

Ladies, do you have any specific wording that you would like to have used in redefinition of reimbursable services, or would you prefer to stand on H.R. 13139?

Mrs. HUNT. We would prefer to have it say "homemaker services," which would encompass both the things that are mentioned, home health aide and home maintenance worker.

Mr. CONABLE. Would that not still be subject to definition by the administering agency?

Mrs. HUNT. Of course.

Mr. CONABLE. And therefore is it not necessary, if you are going to be protected on this, to have something rather more detailed in the way of a definition than simply to call it homemaker services?

Mrs. HUNT. Well, I think it is always necessary to have it tie into an administrative regulation.

Mr. CONABLE. Yes.

Mrs. HUNT. But I think that it would be helpful to have "homemaker services" defined, and we would be glad to help in working with the committee in suggested wording.

Mr. CONABLE. Well, if you had some suggested wording that you would like to submit, I think you have some good points here, and I personally would be interested in seeing this definition considered carefully.

Mrs. HUNT. Thank you very much.

Mr. CONABLE. If you would like to submit something, I am sure we could hold the record open, and have it included.

You say that H.R. 13139 is a modest step in the right direction?

Mrs. HUNT. Yes. We definitely support the bill as a step in the right direction.

Mr. CONABLE. I understand that, but perhaps you would have other suggestions that go beyond that, and if so, we would like to have it in the record.

Mrs. HUNT. Thank you very much.

Mr. CONABLE. Thank you.

Mr. CORMAN. Mrs. Hunt, I wonder if you have a copy of the Federal regulations which result in the very peculiar illustrations you have given us.

I think it would be useful to have those regulations if you could submit them.

Mrs. HUNT. We will be glad to provide them for the committee.

Mr. CORMAN. It seems we find these situations in the kind of medical care that people can have. If a certain part of the body is going haywire, we can cover that, but if something else is wrong, it is just their tough luck.

A stroke patient gets cut off very early, apparently, because of the extended time he would need care. Yet that would seem to be the kind of person who most needs the homemaker assistance.

Mrs. HUNT. That is right.

Mr. CORMAN. If the availability of homemaker services can cut down on the need to put a person in a hospital or nursing home, or keep him there longer, would it not be a good idea to have HEW conduct some experiments with this in mind, to see if it would help keep down medicare and medicaid costs?

Mrs. HUNT. I would think it would be a very good idea.

I am wondering if either of my colleagues would care to speak to either of these points.

Mrs. ADAMS. I think the restrictions have been on the interpretation of the legislation, rather than the legislation.

The last letter we got from the Social Security is the one that really tied us up. It is called Intermediary Letter No. 395.

These are the ones that put the specific little restrictions on, rather than the overall legislation.

Mr. CORMAN. We would like to have those.

(The following was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., August 1969.

Bureau of Health Insurance Intermediary Letter No. 395

Subject: Skilled nursing care provided as a home health benefit.

INTRODUCTION

The home health benefits provided under Parts A and B were intended only for those beneficiaries whose conditions do not require the "around-the-clock" medical and related care provided in hospitals and extended care facilities, but, nevertheless, are of such severity that the individuals are under the care of a physician and confined to their homes. Accordingly, payment may not be made for home health services unless the services were required because of the individual needed skilled nursing care on an intermittent basis, or physical or speech therapy. The purpose of this letter is to clarify several areas of confusion which have arisen in the application of this statutory requirement.

A. Skilled Nursing Requirement.—In defining covered home health services, the law also lists occupational therapy, medical social services, the part-time or intermittent services of home health aides, the use of medical supplies and appliances, and the medical services of residents and interns. Since the patient must be certified as needing skilled nursing care on an intermittent basis or physical or speech therapy in order to qualify for home health benefits, payment may be made for these other home health services only so long as the provision of skilled nursing care or physical or speech therapy is an essential element of the patient's plan of treatment.

The plan of treatment, which must be established and periodically reviewed by a physician, should indicate the types of skilled services required to treat the patient's illness or injury. If the plan of treatment does not indicate a need for skilled nursing care or physical or speech therapy but prescribes only the provision of supportive services, such as personal care services which are rendered by a home health aide, the patient cannot be considered as meeting the certification requirements and is, therefore, ineligible for home health benefits. Consequently, when an intermediary receives an SSA-1487 which shows charges for only, say, home health aide visits or for only medical supplies and appliances, the intermediary should investigate the claim to ascertain whether the physician has certified to the need for skilled nursing services or physical or speech therapy services and made provision for such services in the patient's plan of treatment, whether the patient is receiving such services, and whether the provision of skilled nursing services represents a needed element in the treatment of the patient's illness or injury.

B. Definition of Skilled Nursing Care.—Additional questions have been raised as to what services would constitute "skilled nursing care" for the purpose of applying the above requirements. In defining this term, attention must be focused on the level of skill needed to render the nursing services required by the patient. In this connection the definition of a skilled service found in section 3118.1 should be applied. Specifically, in the home setting skilled nursing care is a nursing service which must be furnished by or under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. Of course, a service is not considered to be a skilled nursing service merely because it is performed by or under the supervision of a licensed nurse. When the nature of the service is such that it can be safely and adequately self-administered or performed by the average, nonmedical person, without the direct supervision of a licensed nurse, it is a nonskilled service without regard to who actually provides the service. The classification of a particular service as skilled is based on the technical or professional health training required to assure the effective performance of the service. Neither the importance of a particular service to an individual patient nor the possibility of adverse effects from improper performance of an otherwise unskilled service will change the nature of a service from unskilled to skilled.

In the home setting, skilled nursing services generally include two components which require specialized health care knowledge and are thereby distinguished from supportive care not requiring such knowledge: (1) the rendition of direct skilled nursing services, and (2) observation and evaluation of the total skilled nursing needs of the patient. Direct skilled nursing services include such skilled services as the administration of prescribed medications which cannot be self-administered, the changing of indwelling catheters, the application of dressings involving prescription medications and aseptic technique, etc.

Skilled nursing observation and evaluation may be required in those cases where symptoms are quite likely to occur which will indicate the need to revise the patient's treatment regimen. In the home health setting, the most frequent examples of skilled observation are in cases in which the patient is receiving direct skilled nursing services and the nurse must visit the patient between the rendition of direct nursing services to evaluate his reaction to the treatment and the possible need to modify the treatment plan. The incidence of situations in a home health setting in which skilled observation is the only nursing service needed is not expected to be frequent since in most cases such patients will need to be more closely observed than is possible under the usual pattern of home care visits. Consequently, where a patient is receiving no direct skilled nursing services, the intermediary should assure that the patient's medical condition is such as to require skilled observation due to the present danger of a sudden adverse change. The immediate post-operative period prior to total stabilization of a condition is one possible example of a case in which a patient may require only the skilled observation of a nurse.

To conserve her time, a nurse may make a skilled evaluation of the nursing needs of the patient at the same time that she makes a visit to supervise the home health aide providing personal care services to the patient. In such cases, the visit may be reimbursed as a skilled nursing visit. (This is not to be confused with a visit for the sole purpose of evaluating a patient's personal care needs and supervising the home health aide. Such a visit is not reimbursed as a skilled nursing visit. See section C below.) Also, while assessing a patient's nursing care needs, the nurse may at times perform service considered as unskilled, such as bathing the patient and/or routine skin care. In such cases where the primary purpose was to render a skilled evaluation, the visit is reimbursable as a skilled nursing visit.

C. Role of Personal Care Services.—In addition to skilled nursing care or physical or speech therapy, a physician may indicate in his plan of treatment that the patient will need personal care services such as help with bathing, ambulation, use of the bathroom, taking ordinarily self-administered medications, and other duties appropriately performed by a home health aide. Since a home health beneficiary must be under the care of a physician for the treatment of an illness or injury which requires skilled nursing care or physical or speech therapy, the home health regulations require that a registered professional nurse assign the duties of the aide and see to it that the duties are carried out. Such duties cannot, of course, be construed as skilled services since they are of the type which can be performed by the average, nonmedical person without the direct supervision of licensed nurses or allied health professionals.

The fact that the conditions of participation require a nurse to visit the patient's home at least every 2 weeks in order to provide *general supervision* to the aide and to evaluate the patient's continuing *personal care* needs does not affect the unskilled nature of the services rendered by the home health aide. Neither would such activities of the supervising nurse represent skilled nursing care of the patient. Consequently, such supervisory visits may not be billed as skilled nursing visits but are considered an administrative cost of the agency. For example, a stroke patient whose condition is stabilized and has no more potential for rehabilitation may require help in getting in and out of bed, getting meals, and meeting other activities of daily living. A nurse would visit this patient to evaluate his personal care needs and, subsequently, to assure that the home health aide is performing necessary duties and that the patient's social and personal care needs continue to be met. While the role of the home health agency in the community may make the furnishing of such services by home health agency personnel entirely appropriate, the patient cannot be considered as meeting the physician certification requirement for payment of home health benefits by the Medicare program. On the other hand, the stroke patient whose condition is not stabilized and, therefore, continues to require medications which cannot be self-administered, restorative nursing care, skilled observation to detect the occurrence of further deterioration, and, perhaps, physical therapy may also require personal care services and help in meeting the activities of daily living. Such a patient would, of course, meet the physician certification requirement and be able to receive all necessary covered home health benefits.

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

Mrs. ADAMS. I think all through the Federal Government you will find, probably in 10 different departments, that we have had demonstrations of the validity of homemaker services, through the Labor Department, and HEW, and Children's Bureau, quite a few demonstrations, and the demonstrations come to a grinding halt.

Mr. CORMAN. Frankly, if you could cite any of those reports for us, that would be helpful, too.

I suspect that this is one area in the health-care field which has not come sharply into focus before the committee.

If those experiments have been conducted, it would be helpful to us to have the reports.

Mrs. ADAMS. We will do that.

(The following is an excerpt from a letter received by the committee from Mrs. Hunt:)

* * * You asked for reports of studies and demonstration projects to support the view that homemaker services (often called home health aide services) are usually less costly than alternative forms of care. A number of pertinent studies have been called to our attention by staff at the Department of Health, Education, and Welfare. One that seemed especially pertinent to your Committee's concerns was done in Clark County, Nevada covering a period from May 15, 1967 to November 30, 1968. Although we requested that a copy of this study be sent to us so that we could send it on to you with our testimony, we have not yet received it. Perhaps you could request it, and other cost studies, directly from the office of Mrs. Stephanie Stevens, 3611 South Building, Department of Health, Education, and Welfare.

(The following letter was received by the committee:)

ALASKA HOMEMAKER SERVICE, INC.,
Juneau, Alaska, December 11, 1969.

Hon. WILBUR D. MILLS,
Chairman, Committee on Ways and Means, Longworth House Office Building, Washington, D.C.

DEAR Mr. MILLS: As Director of Alaska Homemaker Service, Inc., I am endorsing the National Council for Homemaker Services, Inc. filed with you, November 12, 1969. Our Agency has been established by a grant from the Older Americans Act to the Episcopal and Methodist Churches in Juneau. We have

established District Offices in Juneau, and Anchorage and plan to set one up in Fairbanks in January 1970. These three District Offices will make homemaker/home health aide services available to half the population of Alaska.

Alaska is large geographically but small population-wise. Administrative costs and service costs are high because of the cost of living differential. One out of five citizens is Alaska Native—Eskimo, Indian or Aleut. Many of the Alaska Native people live at or below the poverty level. There is a very high rate of suicide among Alaska Natives who are being catapulted from the ice-age into the space age.

Eskimo, Indians and Aleuts are being trained in our training programs to become homemaker/home health aides, to work as part of a team with social workers, nurses and physicians.

Some families can afford to pay the full cost of home care; some qualify for aid from Welfare or the Bureau of Indian Affairs which purchase service from our Agency; but there is a "fringe" group that does not have sufficient funds to pay full cost of care. Many pioneers of Alaska fall into this third group. Expansion of the Social Security Act to provide for homemaker service would be a boon to our older people who are infirm but not in need of nursing care.

The Superior Court Judge is recommending homemaker service to strengthen home life in order to prevent the trauma and expense of removing dependent and pre-delinquent children from their own homes and placed in foster homes and child care institutions. In one motherless family of four, one teen-age child cost the city of Juneau \$3,500.00 in deprecations in 48 hours. After a six months' period of mothering, the Judge and our staff could discern a turning point in the lives of the children. The father was an older man.

Eight months ago, we found a half paralyzed woman of 78 living alone. She did not need nursing services but she did need some one to take her to the doctor, to do meal planning, cooking, and general housework. This intelligent pensioner now is able to walk alone out of doors. Welfare, not medicare, paid for the home help. Another stroke patient called today to request an additional visit of the homemaker to go shopping with her while her husband is at work. This man stayed home from his job for four months to care for his wife. When our Agency opened our office and completed a training program, he was one of the first persons who applied for a homemaker. He was at the point of losing his job and his income. He is in his sixties—a private purchaser—who almost became a welfare client.

The State Department of Health and Welfare needs adequate items in its budget to purchase homemaker service to enable—

1. dependent, neglected and pre-delinquent children to remain in their own homes
2. mothers on aid and low income working mothers to secure trained homemakers rather than babysitters
3. the aged, ill and disabled to remain with dignity in their own homes with their cherished belongings and near their friends
4. low income families to learn from homemakers money management and budgeting

In conclusion, I speak for my Agency in urging Congressional action in broadening the scope of the services of the homemaker/home health aide.

Thank you for reading and listening.

Respectfully,

DOVE M. KULL, A.C.S.W.,
Director.

Mr. CORMAN. Our next witness is Dr. Daniel H. Kruger, Michigan State University.

STATEMENT OF DR. DANIEL H. KRUGER, PROFESSOR OF INDUSTRIAL RELATIONS, MICHIGAN STATE UNIVERSITY

Dr. KRUGER. Thank you very much, Mr. Chairman.

Mr. CORMAN. Dr. Kruger, we are pleased to welcome you to the committee.

If you would like we can put your statement in full in the record at this point. I see it is relatively brief, so that if you would care to

read it, fine. If you want to summarize it, I will leave that up to you.

Dr. KRUGER. I think I would rather summarize it, sir, and call to your attention a couple of the points that I would like to make.

I appreciate the opportunity to appear before the committee to discuss H.R. 14080, because of its relationship to our national manpower policies.

It is my feeling that social welfare legislation wherever possible should interface and interrelate with our national manpower policies.

Our social security program is directed toward several objectives of public policy with respect to manpower in the United States; namely, to provide reasonable economic security against the hazards of old age, disability, and death, and to preserve and enhance the dignity and worth of the individual both as a member of the Nation's labor force and as a citizen.

It seems to me that it is imperative that we improve the Nation's social security system in light of these objectives, plus the fact that if the system is to be effective, it must meet the needs of the beneficiaries in light of changing economic and social forces.

You have heard lots today about the rising cost of living, and the need to raise the level of benefits.

One of the things I am particularly interested in, Mr. Chairman, is the provision dealing with liberalization of the earnings test for retirement purposes, section 5.

This is desirable, because the exempt earnings of \$1,800, as proposed by this bill, is too low. I would hope that we would raise the annual exempt amount of earnings to \$3,000 for the reasons that I have cited in my testimony.

I think the thing I really want to call to your attention, Mr. Chairman, is, since the Congress is in the process of reviewing the overview of our Nation's social security program, I want to recommend a new dimension to our social security programs; namely, to provide widows' educational benefits to those widows of beneficiaries who have youngsters under the age of 18 in their care.

According to the 1966 data from the Social Security Administration, we have approximately 500,000 widows receiving benefits only because of a child under 18 years of age in her care.

I am proposing that those widows under 59 years of age be given the opportunity to improve their employability through education and training.

For example, for those widows under 49 years of age, educational benefits would be provided for a maximum of 4 years. For those 50 to 59 years of age, educational benefits would be made available up to a maximum of 2 years.

The maximum annual education benefit could be, say, \$1,000. The widows would continue to receive their regular social security benefits. The widows' educational benefit would be used to pay the cost of tuition and books up to the annual maximum benefit.

In this plan, I envision the Social Security Administration administering this program, and making direct payments for tuition to the institution in which the widow chooses to take her education or training. The education or training institution would provide the necessary textbooks and other instructional material to the widow, and would bill the Social Security Administration.

There is precedent within the social security mechanism. Moneys are made available for the rehabilitation of disability insurance beneficiaries to improve their employability.

Likewise, the widows' educational benefit program which I am suggesting would enable widows to improve their economic status through education and training.

In 1963, the Social Security Administration conducted a national survey of widows with children receiving benefits under OASDHI, and this survey revealed many things, and I just want to cite some of the findings to you.

For example, the median income of these families was \$3,570, or about 60 percent of the average U.S. family.

We know that the unemployment rate of widows is higher than the rest of the population. We also know that most of the working widows work only part time or part of the year. Many try to get jobs, and cannot.

Furthermore, many of the widows take jobs in which the pay is low because less skill is required, and part-time work predominates. The average monthly earnings for employed widows during 1962 was only \$110, about three-quarters as much as that for all of U.S. female workers.

There is another reason why the widows' educational benefit program should be enacted. No widow receives survivorship benefits after her youngest entitled child becomes 18. This is the case even if that child continues to receive benefits as a student.

Thus, between the time the widow's youngest entitled child turns 18 and the date at which she reaches age 62, there is a widow's gap. During this period she receives no social security payments, and is expected to provide for her own income.

Unfortunately, although the widow mother might reasonably be expected to support herself during the period when she no longer has entitled children in her care, many of these women are poorly prepared vocationally to do so.

I envision the widows' educational benefit program to be financed out of the interest on the social security trust fund. No additional taxes would be required. The only cost of the widows' educational benefit program will depend of course on the number of widows who elect to participate.

If, for example, 200,000 widows participate, and I have suggested a maximum training benefit of \$1,000, the annual cost would be \$200 million. The costs would gradually increase each year for the first 4 years; depending on the number of new widows added to the rolls, but after the first 4 years the cost of such a program would decline significantly.

The reason for the decline is that initially the total number of widows under the age of 59 are eligible to participate, and I am assuming that half may elect to do so. After their 4 years of educational benefits have been completed, the number of eligible widows becomes much smaller.

This kind of program that I am suggesting will enable widows to prepare for careers in a variety of occupations, such as health services, education, community services, all of which are shortage occupations.

The widows as a result of their education and training will be able to get better paying jobs. They will have a salable skill which will enable them to obtain jobs in professional, technical, and managerial fields.

As a result of their improved economic status, their social security benefits will be reduced or withheld. The reduction or withholding of their social security benefits conceivably could offset the cost of this program.

Equally important, these widows will be able to enrich their own lives, and that of their families.

Moreover, the widows' educational benefit program fills an important gap in the Nation's manpower program. These widows represent an important human resource which currently is underemployed and underutilized.

Clearly, the most promising solution to improving their economic status and in eliminating the widow's gap lies in providing these widows with education and training opportunities.

The widows' educational benefit program represents a significant shift in emphasis. Instead of increasing benefits, the program I am suggesting emphasizes human resource development.

In summary, the bill, H.R. 14080, gives the Congress the opportunity to update and strengthen the Nation's social security program.

I would hope that the committee would give serious consideration to raising the retirement test earnings limitation to \$3,000, as well as to raising the level of benefits.

Furthermore, I strongly recommend that the committee include the widows' educational benefit program into the social security program for the Nation. The widows' educational benefit program will enable a group of women in our society to get a new start in life.

Mr. CORMAN. Dr. Kruger, thank you very much.

I must say this is a group of people who potentially are in great need, and who, as I understand it, would not qualify for any kind of public assistance.

Dr. KRUGER. Yes, sir.

Mr. CORMAN. And your suggestion certainly is worthy of careful consideration by this committee.

Do you have questions?

Mr. CONABLE. I have no questions.

Mr. CORMAN. We thank you very much for coming.

Dr. KRUGER. Thank you, sir.

(The prepared statement of Dr. Kruger follows:)

PREPARED STATEMENT OF DANIEL H. KRUGER, PROFESSOR OF INDUSTRIAL RELATIONS,
MICHIGAN STATE UNIVERSITY

MANPOWER POLICY AND THE SOCIAL SECURITY AMENDMENTS OF 1969

The Social Security Amendments of 1969 (HR 14080) underscore the interrelationship between national manpower policies and the Federal social security program. The social security program is directed toward several objectives of public policy with respect to manpower in the United States

1. To provide reasonable economic security against the hazards of old age, disability, and death.

2. To preserve and enhance the dignity and worth of the individual both as a member of the nation's labor force, and as a citizen.

Improving the nation's social security system is essential in light of these objectives. The system to be effective in meeting the needs of its beneficiaries must respond to changing economic and social forces.

For example, the consequences of the rising cost of living in recent years are well known. The Bill recognizes that the purchasing power of benefits has declined as a result of these rising costs of living by providing for a 10 percent across-the-board increase in benefits (Section 2). Even with this increase, retired couples needed nearly \$3900 a year to maintain a moderate standard of living in the spring of 1967 according to the Bureau of Labor Statistics.

My testimony will focus primarily on those sections of the Bill which have manpower implications. Section 5 provides for a liberalization of the earnings test for retirement purposes. This is desirable, but the exempt amount of earnings of \$1800 as proposed by the Bill is too low. I strongly recommend that the annual exempt amount of earnings be raised from the present level of \$1680 to \$3000. The figure of \$3,000 was selected because it approximates the official definition of the poverty income level for a couple. Moreover, I recommend that there be a reduction of benefits of \$1.00 for each \$1.00 of earnings in excess of exempt amount of annual earnings of \$3000. In addition the monthly earnings test should be increased from its present level of \$140 to \$150.

The rationale for raising the annual exempt earnings to \$3000 is that public policy is directed toward raising income levels of those who have been classified as being in poverty. The current level of exemption of \$1680 falls heaviest on those in the lower socio-economic groups where savings, investments, and pensions are minimal. By permitting individuals to have earnings at least equal to the poverty level plus their social security benefits, the nation would have a more equitable retirement system. A combination of exempt earnings of \$3000 and social security benefits would permit the retired worker and his wife to have an income approaching that recommended by the Bureau of Labor Statistics for a retired couple. Such a combined income of earnings and benefits would permit the individual to live with dignity and respect. This too is a national objective.

An annual exemption of \$3000 would give the retired beneficiary a better chance of earning up to the allowable limit of income i.e., \$3000. He could work longer during the year and this appeals to many employers. He could work at positions or in jobs which pay a higher rate of pay. Many beneficiaries, it seems, take low-paying jobs in order to earn less than the \$1680 current annual limitation. Having an annual exemption of \$3000 would permit a better utilization of manpower resources of those 65 years of age or over. It should be noted that in 1968 slightly over 3,000,000 people aged 65 and over were in the labor force. For many of these, work was a necessity in order to earn income to meet basic needs.

In appraising the need to raise the earnings test to \$3000 a year it is important to bear in mind that the average benefit paid to a retired worker in 1968 was \$98.86 a month or \$1186 a year. Assuming that a worker had earnings of \$1600 a year plus his \$1186 in social security benefits his total income would be approximately \$2800. If both he and his wife received a total of \$1800 in benefits and earnings of \$1600 their total income would be approximately \$3400 a year. Again this is below the budget as reported by the Bureau of Labor Statistics. Under the proposed \$2000 exemption plus the improved social security benefits the retired couple would be able to improve their socio-economic status and hopefully escape from poverty.

By providing for a dollar for dollar reduction in benefits above \$3000, a considerable portion of the additional benefits paid would be offset. I do not have estimates of the volume of benefits which would be paid under the \$3000 annual earnings exemption, nor do I know how many present law beneficiaries will be immediately affected. I do not know how many newly eligible persons will be included. Of course, cost estimates are important and these can be calculated. It is, however, equally important to balance social costs with economic costs to the end that the lives of the nation's older citizens are enriched. Income both in the form of benefits and earnings is one of the important keys to life's enrichment.

Section 5 also liberalizes the retirement test for individuals reaching age 72. This is an excellent improvement in the Social Security Act because it would contribute to a better understanding of the rights of the beneficiaries reaching 72. A large percentage of individuals receive over-payments in their social security benefits for the year in which they attain age 72 because of the misunderstanding surrounding the current rule. This change would mean that individuals could start working full time in the month in which they attained age 72 without any reduction in their benefits.

Another manpower dimension of the Bill is Section 10. This section provides childhood disability benefits for a son or daughter of an insured deceased, disabled or retired worker if the son or daughter become totally disabled after age 18 and before reaching age 22 and continues to be totally disabled. This section takes into account that an increasing number of dependents are attending colleges and universities and therefore need protection in event of disability. College trained students are an important human resource for the nation. The extension of the age from 18 to 22 would cover the years in which dependents are in colleges and universities.

Section 9 is more consistent with the trend of early retirement and therefore is an important addition to the Social Security Act. This section changes the computation point for men from age 65 to 62. The current law penalizes the male who retires at age 62 by reducing his benefits by 20 percent. Furthermore, it penalizes the male who retires at age 62 by using the next three years in the formula for determining whether he has sufficient quarters of coverage to qualify and in computing the amount of the benefit. Under the current law the number of required quarters of coverage is determined by counting the number of years up to the year of the man's 65th birthday. In addition, the number of years of earnings which must be used in determining the amount of his benefit is also based on the number of years up to the year of the man's 65th birthday. If he retires under the present law at age 62, the earnings for the next three successive years could be zero and, therefore, his benefits would be lower.

The proposed section removes the current penalty and would encourage early retirement. As is well known, many employers, especially the larger ones have early retirement programs. If this provision were enacted, the worker could retire at age 62 without affecting his level of benefits.

It is estimated that 5 million current beneficiaries will have their benefits increased as a result of this provision. Furthermore, this change will affect 100,000 individuals who do not receive benefits under the present law but would receive a benefit as a result of this provision.

Since the Congress is reviewing the nation's social security program, I want to recommend to this Committee and to the Congress a new program for widows now receiving social security benefits. I suggest that this program be called Widows Education Benefits. As of 1966 according to the Social Security Administration, there were 468,000 widows receiving benefits only because of a child under 18 in her care. The age distribution of these widows were as follows:

Age	Number	Percent
Total.....	468,600	100.0
Under 30 years.....	30,600	6.5
30 to 39 years.....	102,700	21.9
40 to 49 years.....	203,400	43.4
50 to 59 years.....	126,400	27.0
60 and over.....	5,400	1.2

I am proposing that those widows under 59 years of age be given the opportunity to improve their employability through education and training. For example, for those widows under 49 years of age educational benefits will be provided for a maximum of 4 years. For those 50-59 years of age, educational benefits will be available up to a maximum of two years. The maximum annual educational benefit could be \$1000. The widows would continue to receive their regular social security benefits. The Widows Education Benefit would be used to pay the cost of tuition and books up to the annual maximum benefit. The Social Security Administration would administer this program and would make direct payment of tuition to the institution in which the widow chooses to take her education or training. The educational or training institution would provide the necessary text books and other instructional materials to the widow and would bill the Social Security Administration. (The cost of tuition plus books cannot exceed \$1000 a year).

There is precedent for the Widows Education Benefit program within the current social security mechanism. Monies are made available for the rehabilitation of Disability Insurance beneficiaries to improve their employability. Likewise, the Widows Education Benefit program would enable widows to improve their economic status through education and training. In 1963, the Social Security Ad-

ministration conducted a national survey of widows with children receiving benefits under OASDHI. This survey revealed:

"... widowed families had much less income than other families. In 1962 their median income was only \$3,570, or about 60 percent of the average U.S. family. Even on a per capita basis, they had less than three-fourths as much as all U.S. families.

Allowing for size of family, one-fourth of the widowed families had incomes below the poverty level established by the Social Security Administration and two-fifths had incomes below the less stringent low-income level. These percentages are about twice those found in normal families.

Widowed mothers were more than twice as likely as mothers with husband present to be in the labor force (62 percent compared to 28 percent). Even when account is taken of the age and number of children, the same pattern results: in general, widows are twice as likely to work as mothers with husbands.

Although three-fifths of the widowed mothers worked some during 1962, few (about a fifth) worked full time all year. Most of the working widows worked only part time or part of the year. Many tried to get jobs and could not. The widows' unemployment rate was about three times as high as that of other women. Most of the widows who could get jobs worked in such occupations as service, sales, and household work, in which median annual earnings are low because less skill is required and part-time work predominates. The average monthly earnings for employed widows during 1962 were only \$110, about three quarters as much as that for all U.S. women workers."

There is another reason why such a program is needed. No widow receives survivorship benefits after her youngest entitled child becomes 18. This is the case even if that child continues to receive benefits as a student. Thus, between the time the widow's youngest entitled child turns 18 and the date at which she reaches age 62 there is a "widow's gap". During this period she receives no social security payments and is expected to provide for her own income. Unfortunately, although the widowed mother might reasonably be expected to support herself during the period when she no longer has entitled children in her care, many of these women are poorly prepared vocationally to do so.

In addition to the education benefits, funds will have to be provided for limited day care services while the widows are participating in their educational or training program.

The United States Employment and Training Service, U. S. D. L., could be involved to counsel or advise the widows with respect to their choice of a career program.

The Widow Education Benefit program could be financed out of the interest on the Social Security Trust Fund. No additional taxes would be required.

The annual cost of the Widow Education Benefit program will depend on the number of widows who elect to participate. If, for example, 200,000 widows participate, the annual cost would be \$200,000,000. The costs would gradually increase each year for the first four years, depending on the new widows added to the rolls. After the first four years, however, the costs of such a program would decline significantly. The reason for the decline is that initially the total number of widows under age 59 are eligible to participate and I am assuming that half may elect to do so. After their four years of educational benefits have been completed, the number of eligible widows becomes much smaller.

Under this proposal the Widows Education Benefits will terminate if she remarries.

This kind of program will enable widows to prepare for careers in a variety of occupations such as health services, education, community services. These are shortage occupations. The widows as a result of their education and training will be able to get better paying jobs. They will have a saleable skill which will enable them to obtain jobs in the professional, technical and managerial fields. As a result of their improved economic status, their social security benefits will be reduced or withheld. The reduction or withholding of their social security benefits conceivably could offset the costs of the Widows Education Benefits. Equally important, these widows will be able to enrich their own lives and that of their families. Moreover, the Widows Education Benefits program fills an important gap in the nation's manpower program. These widows represent an important human recourse which is underemployed and underutilized.

Clearly the most promising solution to improving their economic status and in eliminating the widow's gap lies in providing these widows with education and training opportunities. The Widows Education Benefit program represents a significant shift in emphasis. Instead of increasing benefits, this program emphasizes human resource development.

SUMMARY

In summary, HR 14080 gives the Congress the opportunity to update and strengthen the nation's social security program. The Committee should give serious consideration to raising the retirement test earnings limitation to \$3000. I strongly recommend that this Committee include the Widows Education Benefit program in the Bill currently being considered. The Widows Education Benefit program will enable a group of women in our society to get a new start in life.

Mr. CORMAN. The committee stands adjourned until 10 a.m. tomorrow morning.

(Whereupon, at 2:55 p.m., the committee adjourned, to reconvene at 10 a.m., Thursday, November 13, 1969.)

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